

Outreach

Strategies for Expanding Health Access in Communities

WORKS



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AHEC/Community Partners

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In the Know...

Outreach Works is essentially the tale of two strategies. When married together these two strategies strike a proven formula for helping uninsured individuals get the health coverage for which they are eligible and access to the care they need. The first — providing families with application assistance in their own communities from people who know the community — is a tried and true method for which there is no substitute. The second — organizing the broad range of community groups and institutions, providers, and public officials to form a supportive, responsive Health Access Networks — provides an anchor for outreach workers and a vehicle for moving forward on new ideas to improve the system. This dual approach has helped to make Massachusetts one of the states that has made significant strides in reducing the number of uninsured residents.”

Donna Cohen-Ross
Director of Outreach
Center on Budget and Policy Priorities
Washington, D.C.

Despite our strong national economy, low unemployment level, and shrinking welfare rolls, the number of uninsured Americans has continued to grow. Today, more than 44 million people living in America do not have health insurance. For them, being uninsured has made a considerable difference in their financial security, access to care and, sooner or later, to their health.

Clearly, one of the largest challenges that we face is how to reach and enroll uninsured people who are eligible for Medicaid and the State Children's Health Insurance Program. Not all eligible disabled people or working-poor families and children are participating in these programs, despite a strong commitment to find and enroll those who would benefit from them.

In 1997, Massachusetts embarked on a multi-modal approach to reach and enroll uninsured people living within the state. We solicited input from, and coordinated our efforts with, other state agencies, municipalities, businesses, medical associations, advocacy groups, and community organizations. By all accounts, the community participation we received was crucial to the success we achieved. We have reduced our overall rate of uninsured to 8%, and our rate of uninsured children to 2.8%.

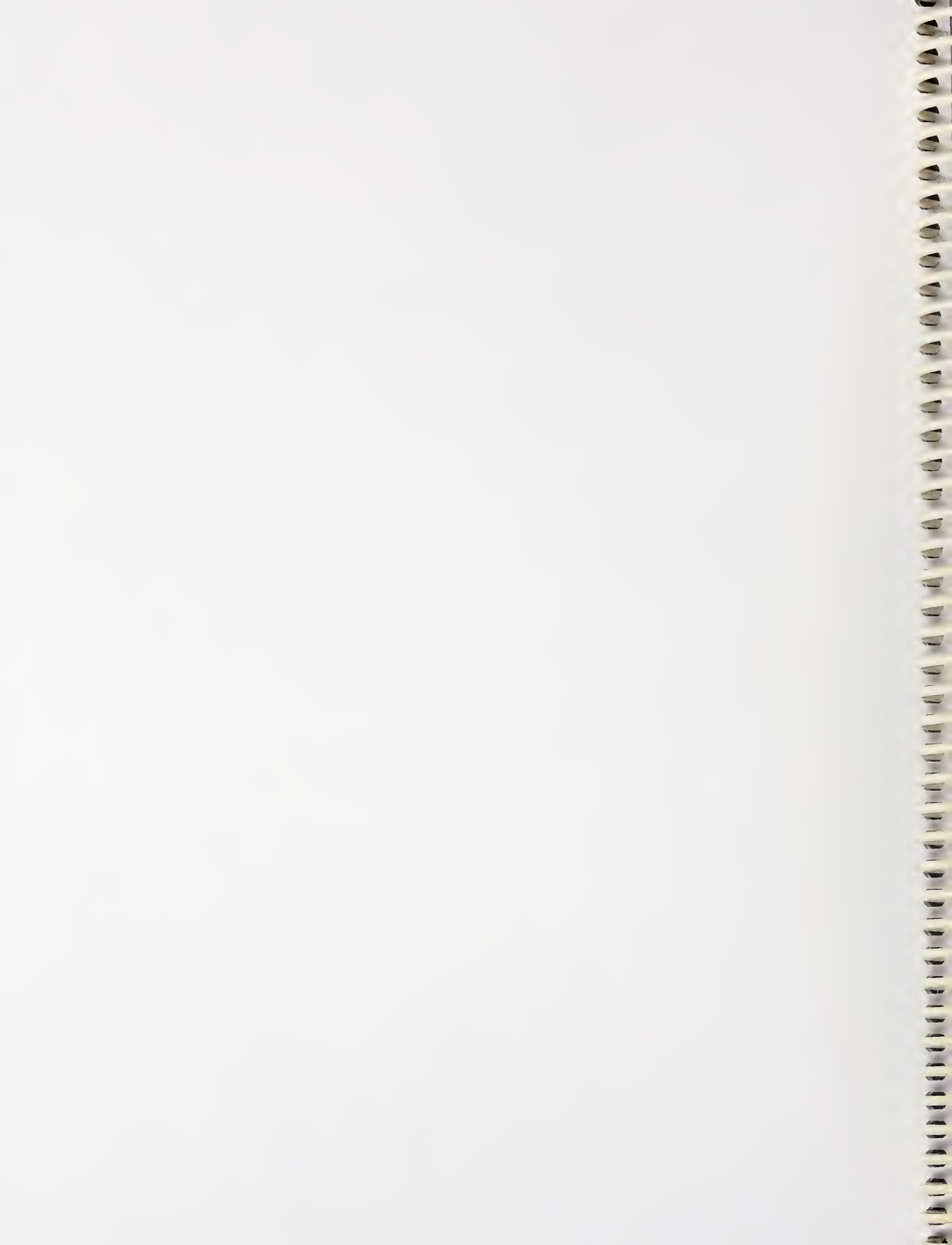
Outreach Works: Strategies for Expanding Health Access in Communities shares the vital importance of state partnership with community-based organizations for effective and successful community outreach. It is a well-documented look at the contribution made by community organizations in Massachusetts to help improve the insurance coverage and access to care for uninsured and underinsured individuals. It is a valuable resource to be used in continuing to strive for increased insurance coverage.”

Wendy Warring
Commissioner
Massachusetts Division of Medical Assistance

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OUTREACH WORKS

**Strategies for Expanding
Health Access in Communities**



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Michael DeChiara
Ellen Unruh
Tom Wolff, Ph.D.
Anne Rosen

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*Dedicated to the millions of Americans
who cannot access the health care they deserve*

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AFTERWORD



Foreword

Academic institutions are always challenged to build bridges to other parts of society that will allow their rich resources to connect to real-life needs. Colleges and universities have a history of working with state agencies and with regional and local communities. Throughout the nation, for example, the Area Health Education Center (AHEC) programs operating within academic institutions have successfully made these linkages to address the health care and health education needs of both state governments and underserved communities. This book, in a dynamic way chronicles the evolution of a program that maintains two spans of a bridge—one to state government and the other to communities.

The first span, itself quite notable, is the development by a public medical school (the University of Massachusetts Medical School) of a working relationship with the state Medicaid agency (the Massachusetts Division of Medical Assistance). The University recognized that working with the state's largest insurance company, with its nearly one million recipients, offered an opportunity to better meet its goals of serving the citizens of the Commonwealth and providing a population base for research and program development. For its part, Medicaid realized that the expertise of the University offered resources for their disease management and quality improvement programs. Medicaid believed it could also call upon the expertise of the University in carrying out some of its evaluation studies and in developing public policy. For the past four years an annual work plan has been developed that brings the two state entities closely together to better serve the needs of the state's most vulnerable population.

The second span, which makes this story most appealing, is the receptive listening the two agencies did when it became time to enroll children in the federal government's Children's Health Insurance Program (CHIP). First of all, they listened to public health experts who advocated using community-based organizations (CBOs) as an important vehicle through which to recruit the uninsured to CHIP. They listened further to the novel idea of providing mini-grants to CBOs across the state, harnessing their local savvy in outreach and enrollment effectiveness. Through grants provided through Medicaid and the Massachusetts Department of Public Health, 50-70 agencies per year have produced phenomenal recruitment results. Secondly, Medicaid listened to the University when it offered its Area Health Education Center (AHEC) Program as the organizing body that would assure the level of outreach worker education and continuous information transfer essential to reaching and attracting consumers to CHIP. This effort resulted in the development of the Health Access Networks, and its story is the core of this book. The second span is something new in government: a reliance on community-based organizations as collaborators in bringing services to hard-to-reach populations.

As an administrator within the University and someone with a commitment to the AHEC model, it has been a source of pride and encouragement for me to see two state agencies willingly working with one another, supporting each other's missions and keeping the community's best interests uppermost in our planning. Furthermore, we realized (wisely) that partnering with community organizations to build a structure that could bring together those in the trenches with an insurance program targeting the underserved offered outstanding potential; and it has, in fact, produced a recruitment effort that is second to none in this state. This has been a most satisfying collaboration.

Michael Huppert, M.P.H.
Associate Dean for Community Programs
University of Massachusetts Medical School
Worcester, Massachusetts

Preface

The United States continues to struggle with its health care crisis. As we begin the 21st Century, approximately 44 million people in the nation are still without health insurance; millions more are effectively underinsured. This affects all residents of this nation, regardless of age, racial and ethnic background, income, where they live, or what language they speak. Almost everyone has the potential to be uninsured or underinsured; our entire society suffers because we lack a collective solution.

In recent years significant steps have been taken to expand eligibility, primarily for children. While making more people eligible is commendable, it is important to understand that eligibility does not equal enrollment, nor is it access to health care services. Real health care access involves getting real people to become enrolled participants in a health care system they know how to use. In Massachusetts we have learned that the key to expanding real health care access is community-based outreach.

Two components have been crucial to Massachusetts' success; in fact, we believe they are essential to any effective health access initiative. The first component is genuine, and culturally appropriate, community-based outreach conducted by people who know how to engage local residents in trusting relationships, and who can provide support and guidance in getting health care coverage. The second is a support system specifically designed to provide outreach programs with networking and information dissemination/sharing opportunities. We have learned that when these two components are used together, community-based initiatives can create significant results.

As you begin this book, you should know why we wrote it. The primary intent was to document the lessons learned from our many partners in Massachusetts: first and foremost, the outreach workers in the field, as well as various state agency staff, health care advocates and partners in the health care delivery system. We wanted to share these lessons in a practical manner, as broadly as possible, to help further the collective effort of expanding health care access in the United States.

This book was also written because we firmly believe that health care is a right, and that we must continue to expand real access to health care for the millions in our nation who remain without adequate health insurance. We sincerely hope that this book contributes to our ultimate goal: making "health care for all" a reality.

Michael DeChiara
AHEC/Community Partners
Amherst, Massachusetts
December 2000



Acknowledgements

This book is the product of true collaboration—of people, institutions, geographic communities and a variety of stakeholders. The stories told and the tools provided are the result of many peoples' efforts, of organizational commitment and expertise, and of joint efforts to truly expand health access in Massachusetts.

First and foremost, we want to thank the many outreach workers across the Commonwealth of Massachusetts who do the real work of expanding access every day in their communities. Their collective passion, ingenuity, determination, compassion, and perseverance have taught us how outreach works, what it can achieve, and what it needs to flourish and be effective. This book is based on the field-tested wisdom and lessons from these many people.

We also wish to thank Mick Huppert of the Massachusetts Statewide Area Health Education Center (AHEC) and the Office of Community Programs at the University of Massachusetts Medical School. Mick's unwavering support of community-based programs, his understanding of how to foster effective partnerships among state institutions, and his willingness to take a risk for a good idea, have been invaluable.

We are fortunate in Massachusetts to have state agencies that have taken leadership positions in expanding health access for our residents. We wish to thank the Division of Medical Assistance, the Department of Public Health, and the Division of Health Care Finance and Policy for their on-going support and commitment to these efforts. This book is physical evidence of the real partnerships that have developed. In particular, the Division of Medical Assistance should be commended for its willingness to look at new ways of "doing business."

Our partners are an integral part of AHEC/Community Partners' ability to be effective. The staffs of Health Care For All, and Salzman and Associates are passionate about making access real and empowering communities. Their involvement in these projects allows us to deliver better services to those in the field. LinkAges Research Group, our outside evaluator, has continually provided us with invaluable insights and, with its thoughtful perspectives, has helped us learn by listening to those we serve.

The people who took this book from "nice idea" to final product were the amazing administrative staff of AHEC/Community Partners. With their diligence and expertise, the team of Amy Casavina, Linda Sharkey, Elissa Small, and Amy Beth Stinchfield made this a book we can offer with pride.

Finally, we want to thank Russell Powell for his initial layout and development work in the early stages of this project, and Rick Schneider for his responsive and thoughtful work on the book cover.



Introduction

This book is intended for those who want to move the issues of outreach, enrollment, and utilization forward by creating effective partnerships with communities. As we have learned in Massachusetts, **outreach works!**

Massachusetts' success enrolling children into health insurance programs is the result of a combination of factors: vision, leadership, innovative partnerships, and effective strategies. The first steps were taken by the state legislature, which opened the door to eligibility, and subsequently by the leadership of the state Medicaid and public health agencies that created the expanded health insurance programs and promoted the mission of enrolling people. Key in pushing these changes forward were the consumer health advocates and their coalition partners including hospitals, community health centers, and provider associations.

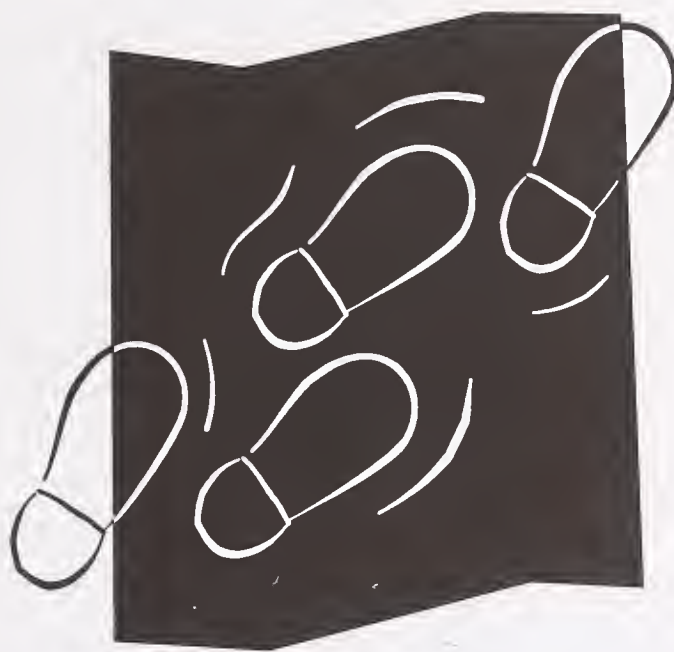
Ultimately, what has made Massachusetts a leader in the nation is work in the communities, where the real results are seen. As we have learned, expanding eligibility for health insurance programs does not equal enrollment. For a variety of reasons, many people who are eligible for these programs, both nationally and in Massachusetts, are not enrolled in them. The barriers to enrollment may be associated with the individual's situation, his or her community's capacity and support services, or the governmental system offering the health coverage. In many of these instances, enrollment can occur if appropriate community-based resources are available. As a result, the real work of reaching 100% access begins after the policy-makers have created the programs, when the outreach begins.

Outreach Works will share strategies employed in Massachusetts to engage communities in the outreach and enrollment effort. It will explore the work of expanding access through outreach, enrollment, and use of health care services; it will look at programs, the creation of infrastructure and related issues. Our hope is to make this information easy to use and adapt.



Section I

The Massachusetts Experience





CHAPTER 1



If We Have the Money, Why is It So Hard?

In this chapter, we will look at the issue of community-based involvement in outreach and enrollment initiatives. Specifically, we will look at the need to establish community partnerships as an effective method for implementing health access policies and programs such as the Children's Health Insurance Program.

We will consider the national issue of outreach and enrollment, followed by the need for ground-level outreach.

This chapter includes:

If We Have the Money, Why is It So Hard?

If We Have the Money, Why is It So Hard?*

In the past few years, U.S. policy-makers have awakened to the fact that eligibility for health coverage programs like Medicaid and the Children's Health Insurance Program (CHIP) is not equivalent to enrollment or improved health status. However, federal and state policy makers who promoted child health laws to expand access are now asking public health officials, "If coverage is available, why is enrollment so difficult?" In the year 2000, when millions of dollars are available to states to increase enrollment-oriented activities, this question and the associated challenge of implementation take on significant implications.

According to the United States Census Bureau, 10 million, or 3.5%, of all children in the nation were without health insurance as of 1999. While many of these children were eligible for health insurance, they remained uninsured. Medicaid and CHIP programs are available nationwide for low- and moderate-income families, but a survey by the Robert Wood Johnson Covering Kids Initiative (August 2000) concluded that as many as 7-million children were eligible but not enrolled in these programs.

The federal government made two significant sources of funding available to states to promote outreach activities to enroll children. The Children's Health Insurance program, established in 1997, allotted \$4.2 billion for additional coverage of low and moderate-income children by states. Additionally, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 provided states with up to \$500 million to ensure that children and parents did not lose their Medicaid coverage as a result of changes stemming from welfare reform.

The problem confronting policy-makers and public health officials is that these efforts are not enough. Neither making more children eligible nor putting aside millions of dollars, even for outreach, will achieve increased enrollment unless these resources are married to an operational understanding of access and the barriers to access. As states begin to address the issue of enrollment in an effort to utilize the millions of dollars available, policy makers and public health officials must understand why families do not enroll themselves or their children when eligible. Indeed, as we have learned about the barriers to access, we have seen that they represent the failures and shortcomings of our health care and safety-net or immigration systems over the past few decades. If states are unable to create an environment that promotes access and effective use of

*Update of article by Tom Wolff, Ph.D and Michael DeChiara, *American Journal of Public Health*, September 1998.

available resources, this opportunity to provide health insurance coverage for millions of children and their families will devolve into another government exercise in spending large sums of money for little result. Health coverage efforts will receive another political and public black eye.

Access is not a new issue, especially for those working in the public health or community organizing fields. For years, lay health advisors and community health workers have been providing primary care to those with limited access to services—whether on Native American reservations, in underserved urban areas, or in rural communities. Community organizing is based on the premise of finding and working with people in the community on issues relevant to their needs. What is relatively new in the past few years is the important linkage of health insurance coverage with issues of access.

In Massachusetts, our initial experience suggests lessons that can serve to guide others' efforts to tackle issues of access and enrollment. Our findings confirm that the community-based model is appropriate for conducting outreach and enrollment activities. The program design uses community health outreach workers as the primary vehicle for program activities, including one-to-one meetings, group presentations, and localized information distribution. After over three years of operation, it is clear that outreach workers are the common denominator in successful efforts to overcome barriers to health care.

Community health outreach workers come from the community they work in and are familiar with its characteristics. With that familiarity, outreach workers can develop and implement strategies designed to address the specific needs of unenrolled populations. Outreach workers are uniquely positioned to understand the myriad situations of children and families lacking health insurance coverage and provide flexible, appropriate responses. In addition, they are vital in the development of community trust and a good reputation "on the street," both of which are critical to successful enrollment efforts. Although there is no one model that fits the unique situations of every community, the experience in Massachusetts leads us to conclude that any successful enrollment program must include community health outreach workers, and a community-based approach.

A successful enrollment program also needs to incorporate several other characteristics into its design. Flexibility and creativity of approach are essential for any program attempting to reach those who have yet to be reached. In addition, programs must emphasize respect for those being served, regardless of economic status, race, culture, primary language capacity, education, literacy level, or the range of life situations that may confront them. Educating people about health insurance options is only part of the task; getting them to trust that an outreach program's services and the health insurance coverage being offered are beneficial and reliable is the greater challenge. After many years of "welfare-bashing," getting this message into a community is critical to successful enrollment, especially when those being invited to apply increasingly come from working families or more vulnerable segments of the community.

Financially speaking, enrollment programs using a community-based outreach model are very cost-effective. Although one-on-one contact within the community may seem expensive and unnecessarily labor-intensive, it is ultimately cost-effective and reliable. When compared with traditional expensive media campaigns that blanket, but do not reach, their target audience, using outreach workers is economical and effective.

Health care coverage and services for residents is a public health responsibility. The federal government and some states have passed legislation to significantly address coverage of the nation's uninsured children (and families). Yet with millions of people residing in the United States still unable to gain access, the need to provide coverage and health care for those who are eligible is essential. Based on the success in Massachusetts and lessons learned elsewhere in the United States, successful efforts must include the principles of community-based partnerships.



CHAPTER 2



The Massachusetts Story

In this chapter, we will look specifically at the community-based programs that form the core of the outreach and enrollment initiatives in Massachusetts: the Health Access Mini-Grant Program and the Health Access Networks. Working together, these initiatives have transformed the health access landscape in Massachusetts and directly contributed to the state's significant Medicaid enrollment and reduced rates of uninsured residents.

This chapter includes:

Creating Effective Community-Based Initiatives

Health Access Mini-Grants

Health Access Networks

Creating Effective Feedback Loops

Effectiveness of These Programs

Replication



Creating Effective Community-Based Initiatives

Massachusetts has developed successful strategies for outreach and enrollment into publicly-funded health insurance programs. By many accounts, the state is doing very well in enrolling children and families, and its efforts are effectively reducing the number of uninsured people, especially children, across the state.

In its report entitled *All Over the Map*, The Children's Defense Fund rated Massachusetts second in the nation for its enrollment efforts for Medicaid and the Children's Health Insurance Program (CHIP). Among states whose CHIP programs have been operating for over one year, Massachusetts' efforts ranked first. According to the report, enrollment from FY97 to FY98 increased at a rate of 10.84% per month over a 24-month period and a total of 179,532 children were newly covered. In addition, the Kaiser Family Foundation reported in Spring 2000 that of the 21 states it had surveyed regarding Medicaid enrollment rates between 1997 and 1999, Massachusetts had the highest increase at 32.4%. This increase is particularly notable in light of the fact that only six states had any increase in enrollment, and 15 states experienced reductions in their Medicaid rolls. The average for all 21 states surveyed was a reduction of 1.3%. These statistics clearly demonstrate that the Massachusetts model is working.

The success of these programs is due, in part, to the decision of the state Medicaid and public health agencies to actively embrace the mission of providing health insurance for more residents. This commitment led to several key developments. In order to make the systems more user-friendly and encourage enrollment, a simplified joint application was developed for the blended Medicaid/CHIP program and the state-funded insurance program for children. In addition, applications were accepted through the mail, and most financial verifications were eliminated.

In 1998, two complementary programs intended to promote community-based outreach and enrollment were created: the Health Access Mini-Grants and the Health Access Networks. Both programs were created in response to an expansion in Medicaid eligibility, and the subsequent federal CHIP initiative that provided additional program expansions. Due to the increased health insurance options provided by Medicaid/CHIP, and supported by thoughtful coordination and implementation of the Health Access Mini-Grants and Health Access Networks, the health access landscape in Massachusetts has been transformed. According to a report by the Massachusetts Division of Health Care Finance and Policy released in August 2000, the number of uninsured children in the Commonwealth dropped from 5.8% to 2.8% in two years, a figure four times lower than the national average.

As an added bonus, these efforts have encouraged a dramatic increase in collaboration between state government and communities working to expand health access and enrollment. Community-based organizations, state agencies, community health centers, hospitals and provider representatives have all participated in initiatives aimed at expanding enrollment and reducing the numbers of uninsured children and adults in Massachusetts. All the major stakeholders agree that together, the Health Access Mini-Grant Program and the Health Access Networks have played a significant role in advancing outreach and enrollment within Massachusetts.

Health Access Mini-Grants

In 1998, the Massachusetts state government, Medicaid and public health agencies joined forces to issue mini-grants to community-based organizations working on health care outreach and enrollment. The objective of the Health Access Mini-Grant Program was to expand outreach and enrollment efforts for Medicaid, CHIP, and the state sponsored children's insurance program. The underlying premise was that community-based organizations could better design and implement strategies for engaging uninsured but eligible residents at the local level. The state agencies would complement these local efforts with program materials, technical assistance, access to information systems, and staff support.

The mini-grant funding agencies came to understand that community-based outreach is an essential and potentially powerful component of any effort to expand health care coverage and increase access to health care. While government agencies, both state and federal, can make policies that create opportunities for broader health care coverage, encouraging people to enroll in these programs and utilize services is the next challenge. This requires partnership with trusted local organizations. In addition, the marketing of these programs requires a complementary, multi-pronged approach involving both state-level initiatives and locally-targeted information. The outreach strategy in Massachusetts was based on the understanding that people often act to enroll themselves or their children only after receiving information between three to seven times through a variety of media or venues.

The grant process was jointly coordinated by the Medicaid and public health agencies that developed the Request For Proposals (RFP). Community representatives and advocates were consulted as part of the RFP development process. Successful candidates needed to demonstrate prior experience either working in the community on health access issues or providing outreach for other community needs. While the selection and procurement process followed state procedures, whenever possible, those with community-oriented perspectives were solicited to participate on the review committees.

Massachusetts' commitment to support community-based partnerships reaffirmed the knowledge that enrollment and increased access often occur on the local level, and that

state government needed local “guides” to the 351 towns and cities in Massachusetts. The outreach effort was designed to support the understanding that effective outreach is based on individual contact, customized outreach, and most importantly, trusting relationships. Community-based outreach partners know where to go and how best to communicate a message so that it is heard; they can serve as effective and reliable sources of information and support. This is crucial: every community is different, and what may work famously in one community may flop in others.

In the first round of health access mini-grant funding (FY99), three state agencies—Medicaid, the Department of Public Health, and the Division of Health Care Finance and Policy—joined together for the first time to provide funding for 52 community-based organizations. Grantees received awards from between \$10-15,000 as part of a total six-month allocation of \$600,000. In FY00 and FY01, the number of grantees expanded to 58 and 84, respectively, with grants ranging from \$10-\$19,000 as part of \$1.2 million annual allocations.

The mini-grants were allocated across the state, successfully distributing funds with the associated mandate to enroll, to a broad range of communities. These communities represent a range of ethnic/cultural/racial populations and service sectors within the state. The geographic distribution extends from the eastern region near Boston to the far west, south and north regions bordering New York, Connecticut and Vermont. Grantee organizations serve both urban and rural communities, as well as specific ethnic and racial populations such as Latino, Vietnamese, and Somali communities. Similarly organizations that serve the homeless, schools, community health centers and Community Action Programs received funding. There was clearly a diversity of experience in providing outreach and enrollment services among the mini-grantees.

The primary expectation of the mini-grant recipients was to provide community-based outreach for Medicaid, CHIP, and the state-funded children’s health insurance program. This would include all forms of local engagement and marketing, with activities ranging from the more traditional, such as presentations, posting flyers, and attendance at community events, to more innovative strategies, such as sponsoring snow day announcements or conducting raffles at the town “dump.” Mini-grantees were also expected to remain responsive to the needs of households they had successfully engaged. Frequently, this meant providing on-going follow-up during the enrollment process to ensure successful navigation of systems challenges and other barriers.

The outreach services provided by mini-grant organizations range widely based upon organizational capacity and community need. Some common outreach strategies span communities, but many organizations seek specific strategies to reflect the character and needs of their constituencies. Mini-grant organizations have become trusted service providers and have evolved into the “go-to” health access experts in their respective communities.

To its credit, Massachusetts established the health access mini-grants to get money to communities so that outreach and enrollment could take place locally and creatively. Often when state governments make grants, the community-based recipients are left to themselves for implementation. Program quality and effectiveness will vary from community to community depending upon the organization's resources, capacity and previous experience.

Health Access Networks

In order to provide systematic support for the mini-grant recipients and other community-based organizations engaging in health outreach and enrollment activities, the Health Access Networks (HAN) were developed by AHEC/Community Partners, a program of the University of Massachusetts Medical School, through funding from the Division of Medical Assistance (Medicaid). The program is based on the premise that regular contact, good information, and understanding of the roles of each stakeholder is necessary to make a government-sponsored initiative effective at the community-level throughout the state.

The program design is based upon three goals central to that premise:

1. Exchange information in a timely manner
2. Share best practices for health access outreach and enrollment (within and across communities)
3. Build linkages and relationships between community-based staff, state agency representatives, and health care advocates.

The result of doing these three things well is a powerful feedback loop that changes health access in the state on every level.

The Health Access Networks were intended from the outset to provide regional forums in which state agencies (primarily Medicaid and public health), community organizations, and health care advocates could come together in a safe space to work toward the common goal of increasing enrollment in health insurance programs for eligible Massachusetts residents. By creating the Health Access Networks, AHEC/Community Partners sought to serve as the convener of these usually disparate stakeholders, and facilitate a process through which they could achieve this goal.

HAN consists of monthly facilitated meetings in which key stakeholders participate in a safe, interactive environment. Meetings are held in six regions of the state, allowing for participation by local community organizations, regionally-based state agency representatives, and statewide health care advocates. Meetings are designed to allow communities, state agencies, and advocates to share updates and information. Special themes are incorporated as appropriate. An average meeting includes from 25-40 people, depending upon the region, and lasts for approximately two hours. Approximately 500 people in the state have participated in the HAN by attending at least one meeting annually.

While the three goals of the Health Access Networks—exchange information, share best practices, build linkages and relationships—seem simple and obvious, successful implementation requires thoughtful coordination.

Exchange Information

Health Access Networks meetings are built on the belief that people need information to do their jobs well and fulfill the mandate they have accepted. With regard to health access it means information about new programs or policies, updates about available resources, and/or an understanding of the broader context of health care politics and current events -- all of which are essential in this rapidly changing field. The Health Access Network meetings engage all participants to share this information. State agency representatives bring whatever program and policy updates they have; statewide advocates provide the broader context; and community-groups report on what they are seeing in the field. By sharing this information on a regular basis, and making it available to all who attend or read the minutes, more people are better informed and subsequently have an increased sense of involvement and understanding.

Share Best Practices

When best practices are shared in meetings or conferences, successes are often highlighted and failures are left undeclared. For those who live in the real world and struggle with limited resources and tough solutions, hearing only about successes does not always serve as encouragement. The Health Access Networks strives to promote sharing in a safe and respectful setting with honest presentations. Community organizations are encouraged to share recent efforts regarding outreach and enrollment, understanding that every community is different and that some things may work in one place and not in another. What failed for one community may be “stolen” by another and be a wild success. With clear modeling and support by the AHEC facilitators, community organizations have come to feel comfortable sharing openly rather than simply presenting success. The trust that this requires often creates a level of honest sharing of experiences that extends to all the participants, including state government and health advocate representatives.

Build Relationships

When all is said and done, most people strive to do a good job and meet the expectations of their position, as they understand it. In health access, as in other sectors, markedly different roles exist with correspondingly different perspectives. These differences are critical to acknowledge, respect and understand, so that effective partnering possibilities can be explored rather than ignored. Since the Health Access Networks meet monthly, there are regular opportunities for participants to go beyond the stereotypes and learn more about the people who do “other jobs.” Over coffee before the

meeting, during jokes and informal moments in the meeting, or simply through exchanges during the regular meeting segments, people come to understand and respect the “other.” State workers, community workers, and health advocates often discover that they are not so far apart in their concerns and their commitment regarding health access. Where there are differences, they become more understandable—or at least better communicated.

Creating Effective Feedback Loops

One of the fundamental functions of HAN meetings is to create a strong foundation for collaboration. The goal is authentic collaboration, which, according to Arthur Himmelman (*Communities Working Collaboratively for Change*, 1992), is “a voluntary, strategic alliance of public, private, and nonprofit organizations to enhance each other’s capacity to achieve a common purpose by sharing risks, responsibilities, resources and rewards.” The Health Access Networks are not merely “feel good” sessions where people talk and drink coffee on a monthly basis; they are forums for dynamic and significant exchange. Over time these alliances have emerged among participants of the Health Access Networks.

Through HAN meetings, lessons and observations from the field can be voiced, acknowledged and documented. The knowledge and understanding of the front-line workers begin the powerful process of sending information “up the ladder” to the policy-makers. This is the beginning of an important feedback loop that rarely exists between government agencies and community organizations. State agency representatives will be asked to share the information from the meeting with their systems and bring a response back to the meeting members. Depending upon the consequences and character of these observations, advocates may also get involved in problem solving on a statewide level.

An essential element in the HAN formula is the presence of statewide health care/consumer advocates. These statewide advocates (in Massachusetts, Health Care For All) provide two important functions for the meetings and to the relationships. Through the advocates’ presentations in the meetings, both community and state government representatives are shown the “big picture” regarding a broad range of health access issues beyond the immediate enrollment and Medicaid/CHIP focus. This broader view provides a context to the work of people in the community and allows for an understanding of the interconnectedness of issues. From the standpoint of relationships, health care advocates offer an avenue for change and accountability beyond the state-community relationship. Since neither their funding nor their mandate is tied directly to expanding enrollment, health care advocates are able to advance issues that require policy development or advocacy.

HAN meetings also provide vital pathways for disseminating information and engaging community organizations. Frequently, government officials or statewide organi-

zations want to inform community organizations about a new program or policy, or to solicit input from them. From behind governmental walls, or when based in the state capital, it is often hard to find these groups without assistance. “The community” can seem elusive and hard to identify. The Health Access Networks serves the very important role of conduit. The meetings provide forums where government representatives can come and engage community organizations.

Since HAN is a statewide program, this feedback and dissemination/engagement dynamic is magnified, meeting a need for all stakeholders. It has become very effective “one-stop shopping,” and increasingly various governmental bodies in Massachusetts are using these meetings for the purpose of providing information and seeking focused input.

The coordinator of the Health Access Networks, AHEC/Community Partners, serves as a liaison between the state government and the communities between meetings. AHEC representatives are in constant communication with higher-level representatives of the state agencies and with the broad range of community organizations. The information that is raised by community organizations is gathered, with themes identified, and brought to the attention of “central office” staff of the state agencies. AHEC staff help coordinate efforts to distribute information, coordinate trainings for community organizations on the behalf of the state agencies, and create opportunities for in-depth forums and discussions. As a trusted neutral liaison, AHEC/Community Partners is able to advance the issues and goals of health access, effectively making government more open and responsive and keeping the communities engaged.

Effectiveness of These Programs

Evidence of the effectiveness and success of the Health Access Mini-Grants and the Health Access Networks can be seen at the national, state, and community levels.

National

Increased enrollment rates in Medicaid/CHIP programs can be attributed in part to Massachusetts’ ability to engage and enroll eligible households through these two community-oriented initiatives.

- The Kaiser Family Foundation report (referenced earlier) identified Massachusetts as having the highest Medicaid enrollments of the 21 states surveyed between 1997 and 1999. The majority of other states saw a decline in enrollments.
- The Children’s Defense Fund report *All Over the Map* (referenced earlier) determined that Massachusetts was second in the nation for overall enrollment rates in combined Medicaid/CHIP programs. For states with CHIP programs in operation for over one year, Massachusetts rated first for its monthly enrollment rates.

- Regional staff of both the Health Care Finance Administration (HCFA) and Health Resources and Service Administration (HRSA) have promoted the Health Access Networks and the Health Access Mini-Grant Program to other states for replication within New England and beyond.
- The National Governors' Association identified the Health Access Mini-Grants program as a "best practice" in 1998.

State

- The Massachusetts Division of Health Care Finance and Policy's August 2000 report documented a significant drop in the rate of uninsured children under the age of 18, from 5.8% in 1998 to 2.8% in 2000. For the entire population, the rate dropped from 8.2% to 5.9% for the same period.
- Over the three years that the Health Access Mini-Grant Program has been in place, more community organizations have become interested in participating in outreach and enrollment; the number of mini-grantees has expanded from 52 to 84 over the three funding cycles despite level/reduced funding.
- The Health Access Networks have achieved a high level of community and state agency buy-in and participation. Since the program's inception in March 1998, more than 1,000 individuals from over 400 organizations have participated in at least one meeting. The vast majority of participants have attended multiple meetings, with a significant percentage regularly attending for between two to three years. Participation in the program includes organizations from 135 distinct communities statewide (38% of the 351 cities and towns in the state).
- State agencies are able to use HAN meetings to distribute information on programs and policies in a more targeted and timely manner. This allows for more effective "rollouts" of programs or policies
- In May 2000, the head of the Massachusetts Medicaid agency credited both the Health Access Networks and the Health Access Mini-Grants with directly contributing to the state's remarkable success enrolling children and families in Medicaid, CHIP, and the state children's health insurance program.

Community

- Staff of the state Medicaid and public health agencies have stated that they are aided in their work by having front-line community workers who are knowledgeable and able to reach people they cannot find or engage. Through the mini-grants and HAN meetings, relationships have emerged with community workers, allowing for more consistent referrals and screening.
- Community-based outreach workers and organizations are increasingly more effective and less isolated as a result of having regular access to timely and reliable information, strategies of best practices and access to state staff, peers and advocates.
- The eligible uninsured and underinsured residents of Massachusetts who are the primary beneficiaries of expanded health insurance programs have benefited from more effective outreach that engages people and services that offer more assistance with the enrollment process.

Key Informant Survey

Comments from recent key informant interviews with participants and stakeholders in the program reflect HAN's success in changing the landscape of health care access in Massachusetts.

"I was surprised to learn how unknowing a lot of the public is about our (Medicaid/CHIP) programs. We take it for granted that people know about existing programs. The (community-based) mini-grant workers have been able to help these people learn about our programs."

- Medicaid staff person

"It's good for us as state people to see and hear directly what's going on from outreach workers. Personal relationships have formed because of face-to-face contact at HAN meetings. It's good for both sides to see the other's perspective, though I don't think it's "sides" anymore. We both see that we have a common goal, and we're now working cooperatively."

– State health program staff person

"The whole concept of meetings that allow sharing of information makes a great deal of difference, particularly the state input and presence, and the networking among agencies that attend. You're often meeting people from agencies that you didn't even know existed, never mind that they're doing the same services."

– Community-based outreach worker

Replication

The Health Access Networks and the Health Access Mini-Grant Program are both easily replicable. The programs can be used to address enrollment and health access issues in other states, cities, or other jurisdictions. In fact, based upon promotion by the National Governor's Association and HCFA, both HAN and the mini-grant program have already been cited as models to inform other states grappling with how to expand health insurance enrollment.

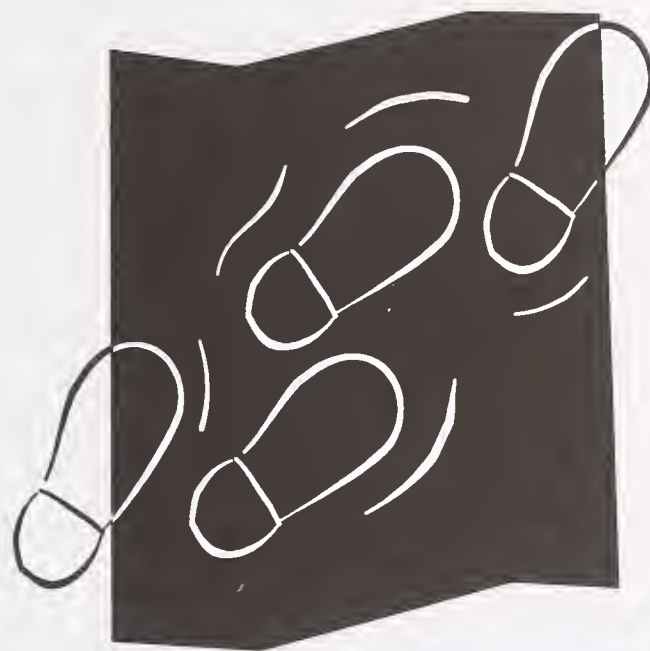
The beauty, and ultimately the effectiveness, of these programs lies in their simplicity. The three goals of the Health Access Networks—share best practices, exchange information and build relationships—can be achieved in many settings if thoughtfully implemented. Similarly, the Health Access Mini-Grants are based on the premise that communities are important partners contributing to a broader initiative to enroll residents. Community organizations that would be excellent partners are everywhere.

The challenge in replicating these two programs is to focus on the function rather than the form. For example, in states larger than Massachusetts, or in states where funding is significantly less, holding 60 Health Access Network meetings annually may be an unrealistic goal. However, structuring a mechanism that convenes stakeholders (community, state agencies and advocates) in a safe environment that is regionally based and promotes the three goals is do-able.

Similarly, a commitment to fund 50-80 community-based organizations to provide outreach and enrollment may be unachievable for some states. However, all states can develop grant programs that solicit the support of locally-based organizations with understanding of communities and interest in advancing issues of health access. The challenge is to provide sufficient funding to those partners, and to support them adequately so that they may be effective partners.

Section II

Outreach and Enrollment





CHAPTER 3



Outreach: The Heart of It All

Community-based outreach and enrollment is at the heart of successful implementation of many health access initiatives. As we have discovered in Massachusetts, people learn about new health coverage programs best in the context of their communities -- with messages that work for them and in settings they frequent. Massachusetts' successful outreach programs have clearly demonstrated that the best way to enroll people is to use outreach workers who know the local mindset, where to go, and the key players to engage.

This chapter includes:

Considerations for Developing Effective Outreach Programs

Article: Health Care Outreach, Retail Style

Article: Massachusetts' Children's Health Programs Seen as Models

Sample Outreach Worker Job Description



Considerations for Developing Effective Outreach Programs

As outreach becomes more of a priority in communities and within health care systems, an understanding of how to develop and implement a successful and effective program will become increasingly important. Here are some key issues to consider when developing community-based outreach programs:

Staffing

Active supervision of outreach programs is particularly important to:

- Ensure that outreach workers with knowledge of the community are hired;
- Pave the way for staff to network with health and medical care providers and community organizations;
- Promote understanding of health care programs, ensure that opportunities for continuing education strengthen existing skills, and build new ones; and
- Provide assistance with case review and drawing boundaries for involvement with participants.

Teamwork among outreach staff is advantageous because staff can:

- Help with coverage issues (staffing the office, making presentations, working with consumers);
- Promote field-based problem-solving;
- Teach one another, share existing and new skills, and provide helpful hints; and
- Maximize talents and knowledge of staff by complementing responsibilities.

Services

Organizational preparation is important. This includes developing systems such as manuals, establishing protocols and making information available concerning:

- “Who’s who” in the service area;
- Health-care services/benefits, including availability and corresponding eligibility requirements;
- Scripts for conversing with clients, including questions to ask;
- Methods for assigning cases; and
- Systems for tracking cases, activities, and sharing information.

Integrating services is important for outreach to be effective.

- Outreach programs should be integrated with other services offered under an umbrella agency.

- Outreach staff should be knowledgeable about other services within the agency, community and vice-versa.

Physical Space

The location and “feel” of an outreach office is important. When possible, the space should:

- Be on a major transportation line (if available) or a well-traveled route;
- Be accessible to the disabled;
- Have a private area for meeting with clients;
- Provide a cheerful environment; and
- Be able to accommodate children during interviews.

Training

There is no substitute for a well-trained and knowledgeable outreach worker. Training methods may include:

- Modeling by other workers or a supervisor experienced in outreach;
- Supervised case review for educational purposes;
- Identifying resources for keeping current with the constant changes in health care;
- Time on the job; and
- Formal training programs (rural or isolated areas may need innovative methods to connect workers at different sites to one another, such as distance learning or internet access).

Training subjects may include:

- Defining boundaries in interactions with clients;
- Understanding how to work with a broad range of consumers;
- Identifying and reporting on domestic violence;
- How to conduct home visits;
- Developing methods for networking with providers and community organizations; and
- Gaining information about changes in public health insurance programs, such as participant eligibility

Getting the Word Out

Outreach focuses upon both consumers and other service providers. Outreach staff seek to raise awareness of the health coverage services available and to build consumer and provider confidence in the outreach program. Service providers include, but are not limited to: medical, health and human services, schools, places of worship, community and neighborhood groups, employers and business groups.

New outreach programs need to develop a prioritized strategy for getting their message out. There are many possible avenues for outreach. It is helpful to think about concentric circles (zones) which represent different types of outreach, starting with those which are easiest and most comfortable and moving toward less familiar and more challenging ones. The goal is to start with easier areas to gain success and gradually expand the outreach outward.

Examples of Outreach Zones

Zone One:

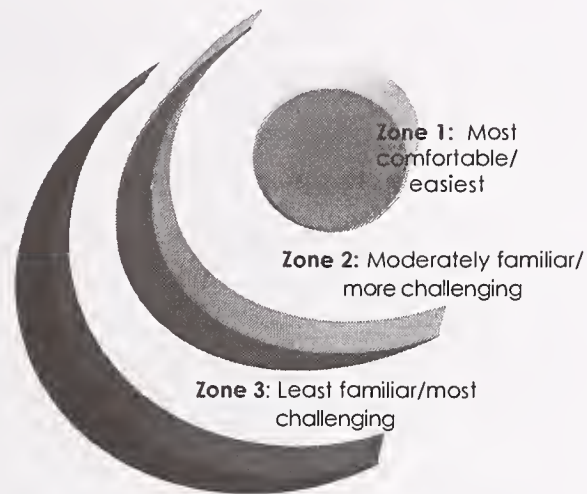
- Provide in-service or referral information to other programs in your organization
- Conduct outreach activity for a community group well known to you

Zone Two:

- Offer a training or information session to office staff at a local medical provider's office
- Participate in joint outreach activities with school nurses in a school setting

Zone Three:

- Establish relationships with informal community leaders not known to you, and ask them to sponsor an outreach activity at which you will speak
- Conduct a presentation for a human service agency that already has outreach workers, but is unfamiliar with health programs, to determine how your program can help them.



Outreach activities include distribution of materials, meeting with people or groups, and getting people the health care coverage they need. Outreach workers need to be creative, determined, knowledgeable, and trustworthy.

Common wisdom tells us that people need to hear about something three to seven times before they act, so outreach needs to be varied and constant. The keywords for an effective outreach program are repeat, repeat, repeat and follow-up, follow-up, follow-up.

Pages 25-27 are derived from a report of interviews with staff of the Healthy Connections Outreach Program in Massachusetts, conducted by LinkAges Research Group, Inc. (see Chapter 11, *Outreach Resources*, for information on LinkAges Research Group.)

“Health Care Outreach, Retail Style”

Linda Goodspeed, *Health Care For All News*, Fall 1998, Vol. 10, No. 2



You’ve heard of Thelma and Louise. Laverne and Shirley. Now meet Fran and Judy, North Quabbin’s own larger-than-life stars of health-care access.

“Someone once told me that people have to see something three times before they remember it,” Judy said. If that’s the case, it hasn’t taken motorists in North Quabbin long to remember Francine Howard and Judy Grant, and their message of health-care assistance. In fact, it’s hard to miss them. The two local women work for Healthy Connections, a rural health outreach program run by Athol Memorial Home Health and Hospice. They are part of a state-funded outreach initiative to find uninsured families and link them to health-care programs. One way Fran and Judy are finding families in North Quabbin is from the long-time empty and rundown billboard on School Street in Athol. Call it highway beautification through health-care access. “It’s become quite a conversation piece around town,” Fran said. “Several people told me they almost ran off the road when they saw me up there,” added Judy.

For the uninitiated, North Quabbin is not a place; it’s a whole lot of places—nine communities in all stretching across the hills and valleys of north central Massachusetts. No trains, trolleys or buses link the towns or the people who live in them. Just winding country roads that both connect and isolate residents.

“Many families have been here for generations,” said Judy Grant, herself born and raised in the area. “It’s not a high income place. People work hard; they just don’t make a lot of money.” Fran Howard, who was born in the area and moved back ten years ago, agrees: “People know each other. They look out for each other.”

Since Fran and Judy's picture and their message of health-care assistance began appearing in local weekly newspapers and on the Athol billboard, they have helped dozens of families in the area find the health-care assistance they need.

They offer help with doctor visits, prescription drugs and medical-related transportation. Part of the deal is that all callers must first be screened for eligibility for MassHealth (Medicaid) and other state and federal health-care programs. Michael DeChiara, director of health-care access programs at the Area Health Education Center (AHEC) in Amherst, who helped the women write the grant for the state-funded program, says the strategy is similar to the retail industry's concept of the "loss leader." "Fran and Judy are like the department store that advertises socks on sale just to get people in the store. Then they sell them the whole suit."

Instead of socks, Fran and Judy advertise health-care assistance; when people respond to the ad, instead of selling them a suit, Fran and Judy screen them for MassHealth eligibility. The concept of the "loss leader" seems to work as an outreach strategy as well as it does for retailing. "In the first two weeks of July, I had 11 calls and Judy had ten, and half of them were eligible for MassHealth," Fran said.

For callers who are not income-eligible for MassHealth or other publicly funded health-care programs, the women are able to provide vouchers for doctor visits, prescription drugs and transportation. The North Quabbin voucher program is one of several state-funded "demonstration" projects to encourage local initiatives that reduce use of hospital free care and emergency services, and to increase enrollment in MassHealth and other government health programs. Health Care For All, AHEC, and other activists have been lobbying the state for more than a year to increase grassroots outreach efforts.

Many of the state-funded "demonstration" projects in urban areas are relying on health centers to enroll uninsured people who do not qualify for MassHealth and other programs. There are no health centers in North Quabbin—one of the unique health-access issues in rural areas. Instead, Fran and Judy have organized a network of providers in the area who have agreed to accept vouchers from patients in exchange for a fixed reimbursement. But they are able to give out just two vouchers per patient. "It's not a solution," admitted Fran. "It's a one-time shot for people with an acute health-care problem."

If applicants are ineligible for prescription drug assistance programs, Judy and Fran can provide vouchers for limited drug refills. Because transportation is another unique and pressing need in rural areas, the North Quabbin demonstration project also includes vouchers for rides to doctors and other health-related services. "We had a young fellow who had a horrible heart attack," Fran said. "He had insurance, but had no automobile or way to get back and forth to the doctor. We were able to access transportation for him."

"We do the best we can to make sure people get the services they need," added Judy. It's what Fran and Judy call "a larger-than-life" message.

Massachusetts' Children's Health Programs Seen as Models

Aglaia Pikounis, *State House News Service*, Boston, June 1998

A national group that recognizes "best practices" reports that Massachusetts is doing a good job of making sure that children are insured.

Specifically, the Commonwealth's Child Health Outreach Strategies—its attempts to identify uninsured children and enroll them in the state's Medicaid program—are among the best in the country, said Becky Fleischauer, media spokesperson for the National Governor Association's (NGA) Center for Best Practices.

An estimated 160,000 children in this state do not fall under an insurance plan, according to a Children's Hospital newsletter.

"Massachusetts is a leader in health care, and the federal government has used its innovative and progressive programs as models," said Kate Weldon, research analyst for the Children's Legislative Caucus.

With the passage of the Health Care Access Bill two years ago, the state expanded two key health-care programs for children, MassHealth—the state's version of Medicaid—and the Children's Medical Security Plan (CMSP). These programs are paid for with a 25-cent per pack cigarette tax.

A special "mini-grants program" enables 50 community groups to find uninsured children and mothers and enroll them in these two health programs. This unique outreach effort was recently profiled by the NGA's Center for Best Practices.

As part of last year's budget, the Cellucci administration awarded one-year grants of between \$10,000 and \$12,000 to community groups statewide "to do outreach for children and adults without insurance," said Allison Staton, policy analyst for Health Care for All. It is a little-known five-month-old project that allows different communities to help their own community members, said Staton.

"Community groups know better what their needs are," said Staton. She said the Department of Public Health and the Division of Medical Assistance selected the groups that applied for funding. The groups include a housing development in Somerville, a parents' club and a Cambridge child-care center.

Several of the organizations that received funding are just starting to enroll children and are hoping their grants, which run out at the end of this month, are extended.

“We’re not in the field of health care so we needed training,” said Jennifer Murphy, public policy manager of the Child Care Resource Center in Cambridge. The non-profit, private center received \$10,000, most of which was used for staff training. “We’re just starting to see the fruits of what we’re doing,” she said.

As part of the center’s Health Access Project, counselors ask parents and children if they have health insurance when they are applying for child care. In most cases, the counselors know the family income and can determine whether the child and mother are eligible for MassHealth or whether the child should be enrolled in the CMSP.

To receive MassHealth benefits, a family of three must earn less than \$17,800 a year* (gross), said Murphy. A family of three earning less than \$26,700 (gross) is eligible for CMSP at no cost, according to the DPH Web site.

Once eligibility is established, the counselors must then complete insurance forms. But first, the center’s counselors had to learn how to complete the complicated and often tedious documents.

Murphy said this was not an easy process. Staffers needed several months of training to learn how to fill out various forms and to teach the center’s network of child-care providers. Now the state has created one unified form, the Medical Benefit Request, that will be easier to complete. The center is waiting for those forms to arrive in the mail.

The center’s counselors also discovered that many families don’t want to enroll in state health programs.

“We have found that there are a variety of reasons why families do not have health insurance and why they do not visit health centers. A lot of the families that we have spoken to see this as public assistance,” she said.

A bigger barrier, Murphy said, is that their income makes them ineligible.

“A lot of them are over the income.” This has been particularly discouraging for Murphy, who says that on one occasion a family was ineligible because it earned \$230 more than the required yearly salary.

* According to 1998 Federal Poverty Guidelines; these guidelines are adjusted annually. To see the current guidelines, visit <www.ahecpartners.org/hca>.

Sample Outreach Worker Job Description

(Providing community-based outreach, enrollment and post-enrollment services)

Position:

Community Outreach Worker (titles may vary) – xx hours per week

Reports to:

Sally Supervisor

Program Coordinator, Centerville Health Access Program (CHAP)

Goals:

Increase the number of Centerville residents who have access to health care services by finding those eligible for publicly-sponsored insurance programs and other resources and assisting them to apply successfully. Create referral networks among other programs that can assist with the provision of health care services. Ensure that newly-enrolled members of publicly-funded insurance programs understand how their insurance plan works and have a functional relationship with an appropriate primary care provider. Perform community outreach and marketing to increase Centerville Health Access Programs' (CHAP) effectiveness in addressing health care access issues.

Responsibilities:

1. Assist clients to apply for appropriate health care coverage plans, providing necessary follow-up, tracking and data collection.
2. Initiate post-enrollment support activities with Medicaid/CHIP eligible clients, completing and recording the information required for monthly reports.
3. Serve as a central resource for community questions and referrals for both consumers and providers, building relationships with outreach workers, community resources, and providers to help identify and solve problems.
4. Work closely with state agency staff for Medicaid, CHIP and public health, and with other community outreach workers and agencies to identify potential consumers of the system and to provide them with current, accurate information and assistance, when necessary.

5. Attend appropriate community or networking meetings to facilitate outreach and gathering of information to increase effectiveness of Centerville Health Access Program.
6. Work with local medical providers' offices and key employers to train, coordinate and problem-solve so they can make appropriate referrals to Centerville Health Access Program or appropriately support enrollment in or use of services through Medicaid and CHIP.
7. Prepare or identify educational flyers/handouts to distribute through local health and human services networks and other community-based groups and collaborate on marketing efforts.
8. Develop and maintain a tracking and follow-up system for Medicaid, CHIP and other applications to ensure that all aspects of the process, from application through post-enrollment, have been completed and that the client is able to receive appropriate services.
9. Maintain statistics/data on contacts, identify needs, problems and service gaps. Track and tabulate contacts, application submission and post-enrollment follow-up.
10. Meet regularly with the Centerville Health Access Program supervisor to review activities, identify priorities.



CHAPTER 4



Healthy Connections: Case Study of an Outreach Program

Healthy Connections was established in three rural regions of Massachusetts in 1997 and quickly established a reputation for excellent work in outreach and enrollment. Two of the sites, North Quabbin and the Lower/Outer Cape Cod, continue to provide excellent health access-related services in their communities. The Northern Berkshire site has been folded into another successful health access program.

This chapter will look at ground-level issues including performance statistics, findings of the program evaluation, a case study of a typical household served by the program and forms for tracking activity.

This chapter includes:

Advancing Health Access
on the Community Level

At A Glance

Program Effectiveness

Field Observations

Case Study of a Household
Working With an Outreach
Program (Part I)

Sample Forms for Intake and
Tracking of Outreach Activi-
ties

Advancing Health Access on the Community Level

The last few years have seen dramatic changes in health care in the United States, yet the number of people without health insurance is in the millions and continues to rise. As policy makers attempt to make health coverage more available, especially to working families and other previously ineligible members of our society, they must grapple with how to successfully engage and enroll people who have yet to be reached.

Healthy Connections, a federally-funded Rural Health Outreach Program of AHEC/Community Partners and Outer Cape Health Services, was started in 1997 to address the issue of health care access for those without insurance. The program operated in 26 rural communities in the Northern Berkshire, North Quabbin and Lower/Outer Cape regions of Massachusetts. Healthy Connections used community-based outreach as the means for finding and successfully enrolling hundreds of households and individuals in health care and related programs.

Community-based outreach is essential when trying to find people in rural communities who do not have health insurance and who, once found, need support to get through the hurdles of the health care system to become enrolled. Outreach requires going “where the people are” and knowing how to address their situations—their needs, their concerns, their questions. Healthy Connections outreach staff live in the communities in which they work. They know the community, the people, and most importantly, they know the barriers which prevent people from getting health insurance and health services.

A myriad of issues keeps people from enrolling in and using health-coverage programs—some logistical, some systematic, others attitudinal. They include a lack of information about health care options and the details of eligibility, an application process which is often not easily understood or navigated, little or no public transportation, and a broadly-held perception that publicly-funded health insurance is a hand-out for the undeserving. All of these barriers, as well as a range of others, must be understood and addressed on the community level by the Healthy Connections outreach worker. It has been demonstrated that only by building trust and providing individualized support can many of these issues be overcome.

One of the truly exceptional components of an outreach program is its ability to provide follow-up. Helping people get enrolled often takes weeks, if not months. Traditional programs and generalist caseworkers are unable to visit homes, check in regarding the enrollment process or initiate creative solutions over a period of time. This is what Healthy Connections does, and it often makes the difference between becoming

enrolled or remaining vulnerable to the vagaries of one's health.

One Healthy Connections outreach worker recently celebrated getting health coverage for a mother and child after eight months of persistent follow-up.

As a result of its effectiveness and statewide focus, Healthy Connections has taken a leadership role in the developing arena of health access outreach. Healthy Connections outreach staff are actively involved in a variety of initiatives to address the need for health care access and services in their communities. Staff have been strong advocates and active participants in statewide efforts to increase access and improve programs.

This focus on access has led to the identification of gaps in health care services. Especially in rural areas where health care providers are few, even those with insurance face challenges of access resulting from a lack of local services. In response, Healthy Connections has worked closely with regional Community Coalitions as well as local organizations and providers to address these pressing needs. Without the ability to receive necessary health care services, a person with insurance is left with a plastic card but nowhere to turn.

Clearly health care access will continue to be a challenge as long as there is a patchwork of programs providing health coverage and services. Within this crazy quilt system, outreach is the essential thread, weaving sense and continuity. Fortunately, in Massachusetts Healthy Connections has become a "tailor of necessity," successfully working to connect those without health care to the services they need.

At A Glance

Mission

Healthy Connections works in partnership with communities—residents, organizations, and human service providers—to improve the state of public health in rural Massachusetts. The program integrates community-based outreach and advocacy to promote greater access to services for people and increased capacity within communities.

Goals

- Increase access to health care and other services for the rural uninsured and underinsured
- Increase local capacity to address health issues within the community
- Promote policy that supports outreach efforts and community development regarding health issues
- Promote increased coordination and collaboration for health care and other needed services among providers in the community

Program Focus

The original Healthy Connections program focused on three distinct regions of Massachusetts—the Lower/Outer Cape, the North Quabbin and the Northern Berkshires. These regions consist of communities which have been federally designated as “Medically Underserved Areas” and whose residents have been federally designated as “Medically Underserved Populations.”

- Lower/Outer Cape Cod (8 communities in southeast part of state)
- North Quabbin Region (9 communities in north central part of state)
- Northern Berkshire Region (9 communities in northwest part of state)

Program Participants

The host agencies for the Healthy Connections program have represented a range of organizations within the health and human service sector.

Lower/Outer Cape region

Community Health Center (Outer Cape Health Services, Inc.)

North Quabbin region

Hospital Visiting Nurse Program (Community Health Service of Athol Memorial Hospital)

North Berkshire region	Community Coalition (Northern Berkshire Community Coalition); hospital-based health access program (EcuHealth Care, Inc.)
Program Coordination	AHEC/Community Partners (program of statewide AHEC system specializing in community development)

Program Staffing

Over the three-year period that the program was fully operational under its original grant design, staffing levels ranged from five to nine outreach workers. Each site had 1.5 full-time equivalent positions; all employees were part-time. Outreach staff had a variety of professional and educational backgrounds, ranging from high school graduate to graduate school. Ages ranged from early twenties to fifties. All outreach staff were female and Caucasian (which reflected the demographic character of their communities).

The Healthy Connections program was located in three rural regions of Massachusetts—Lower/Outer Cape Cod (southeast), North Quabbin (north central) and Northern Berkshires (northwest).



Program Funding

Healthy Connections was originally funded by a three-year grant from the U.S. Department of Health and Human Services, Office of Rural Health Policy. Subsequent support has been through the Massachusetts Health Access Mini-Grant program and the Massachusetts Covering Kids Initiative. Matching support has been provided by the participating organizations.

Program Effectiveness

The Healthy Connections program operated from February 1997 to June 1999 with three regional sites as part of its original Rural Health Outreach Grant. The program began prior to the enactment of the Children's Health Insurance Program, and over the course of the three years it developed into a model for other outreach programs in Massachusetts.

During this time the program was continually reviewed by an outside evaluator, LinkAges Research Group, Inc. (see Chapter 11, Resources, for more information.) By all measures, the program was very successful. The evaluation included community forums with human services providers, data collection and analysis on services provided, and a phone survey of consumers of the program. In addition, the program greatly contributed to issue identification regarding outreach—and health access generally—in Massachusetts.

Services Provided

During the 29-month period from February 1997 to June 1999, Healthy Connections served a total of 2,061 households and 4,194 individuals in 64 towns. Those served included people of all ages in a variety of household configurations. They came from varying racial and ethnic groups, had a broad range of incomes and employment status, and included people who were uninsured or underinsured, and even some currently insured but needing assistance.

Outreach workers in the Healthy Connections program were asked to document the services provided to consumers based upon how their activities fit into the continuum of outreach and enrollment. Specifically, service actions could be: referrals (R), enrollments (E), confirmation that health care services were received (S), general assistance not related to enrollment (A) or follow-up (F). Each of these actions was considered a distinct service action. During the 29 months the program was fully operational, Healthy Connections outreach workers provided 14,237 distinct services actions to the people they served. This number increased annually over the course of the program.

By the last year of the program the outreach workers' increasing skill at screening for eligibility led to a success rate for referring and enrolling individuals in Medicaid or CHIP of 71% plus*. The Healthy Connections staff were clearly outreach and enrollment experts, familiar with the broad range of health access programs available to residents of the state—from Medicaid and CHIP to state-funded programs meeting the pharmacy needs of the elderly and disabled and the preventive care needs of children. Furthermore, community fo-

runs clearly indicated that the Healthy Connections program had become an integral and necessary component of each community's referral network, providing comprehensive and accessible information regarding health access options.

Total Served	
Households Served	2,061
Individuals Served	4,194
Total Services Provided	
Referrals Made	4,551
Enrollments Confirmed	2,458*
Follow-Up Made	4,710

* The actual enrollment figure is presumed to be higher. Documented enrollment reflects only those enrollments directly confirmed by outreach staff.

Field Observations

After 3 years of Healthy Connections activities, several findings have emerged.

Outreach workers in the communities:

- can reach large numbers of people
- know best how to engage the people in their communities--where to go, what to say and through what media
- serve as community-based marketing representatives for publicly-funded programs such as Medicaid and CHIP
- provide a positive gatekeeping role by assisting in screening and application processes
- serve as the first line of troubleshooting for residents experiencing problems with the application and enrollment process, billing, or in gaining access to services

A successful community-based outreach program:

- depends on establishing a trusting relationship with residents
- gains a place in the community through “word of mouth” referrals
- becomes the health care expert and advocate for a broad array of residents’ health needs

Observations regarding the services provided:

- as clients move through the continuum (from outreach, through referral and confirmed enrollment, to actual use of health care services), the number of contacts they have with the outreach program declines
- constant follow-up is necessary throughout the many steps of the outreach and enrollment process
- the number of follow-ups required is just as large as the number of referrals
- some households require a lot of follow-up, others require much less

Case Study of a Household Working with an Outreach Program (Part I)

Roger Scofield*, 32, suffers from chronic back pain. He is a carpenter by trade, and works as a subcontractor when he feels able. He's self-employed and has no access to group insurance. His condition hasn't been definitively diagnosed; he is not eligible for any kind of disability benefit. His gross earnings average \$2,000 per month.

Roger and his wife, Mattie, 29, have three young children at home. Jeff is 12, Wyatt is 8, and Carrie is 11 months. Mattie helps out by doing a little child care in their home, averaging \$150 gross per week during the school year. Mattie's thyroid condition requires regular monitoring, but she has no health insurance and can't afford testing.

The Scofields are hard-working and proud of their independence. They have never asked for help from anyone. They don't subscribe to the daily newspaper published 40 miles away, so they haven't read about expanded health insurance programs or seen any ads.

Jeff is Mattie's son by a previous marriage, and his father has provided health insurance for Jeff until four months ago, when the father moved to California. Jeff's chronic asthma has caused the family great concern. When Mattie was unable to pay for an inhaler for Jeff, her local pharmacist gave her a flyer and encouraged her to contact the outreach program for help.

Anxious to help her son, Mattie called right away. Joanne, the outreach worker, explained that Medicaid was health insurance, not welfare. Reassured by Joanne's friendliness and competence, Mattie began the application process. Because both Mattie and Roger are self-employed and keep informal records of their income, the income verification process was quite time-consuming and required a number of follow-up contacts. At the Scofield's income level, the children are eligible for comprehensive Medicaid coverage; Roger and Mattie would not be eligible, unless they had access to insurance through an employer.

During the application period, Carrie had a severe intestinal infection that required hospitalization. Mattie immediately called Joanne who was able to advocate within the state Medicaid system to expedite the application so the hospitalization would be covered.

* The Scofields are a fictional composite of families served by the Healthy Connections Program.

The forms on pages 46-50 document the progress of the family through the outreach program. These forms enable the outreach worker to track the family's progress. They also provide data that ultimately informs the evaluation and future program design.

Once the three children have been determined eligible for coverage, the next stage of the process is connecting the family to appropriate health care resources. That story begins on page 123.

HEALTHY CONNECTIONS INDIVIDUAL/HOUSEHOLD BACKGROUND INFORMATION																																																																																																
HOUSEHOLD IDENTIFICATION First Date of Contact with Healthy Connections: <u>2/3/2000</u> Address: <u>122 State Road</u> City: <u>Pleasantville</u> Zip: <u>00000</u> Home Ph: () - - - - - Alt. Ph: () - - - - -						CONFIDENTIAL																																																																																										
	First Name	Mid.	Last Name	Relationship	Indiv #																																																																																											
Head of Household	<u>Mattie</u>	<u>C</u>	<u>Scotfield</u>	<u>Self</u>	<u>00</u>																																																																																											
Household member	<u>Roger</u>	<u>T</u>	<u>Scotfield</u>	<u>Husband</u>	<u>01</u>																																																																																											
Household member	<u>Jeffrey</u>	<u>A</u>	<u>Taylor</u>	<u>Son</u>	<u>02</u>																																																																																											
Household member	<u>Wyatt</u>	<u>R</u>	<u>Scotfield</u>	<u>Son</u>	<u>03</u>																																																																																											
Household member	<u>Carrie</u>	<u>M</u>	<u>Scotfield</u>	<u>Daughter</u>	<u>04</u>																																																																																											
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Household member					<u>07</u>																																																																																											
Primary Reason for Contacting HC: <u>Couldn't afford prescription - no insurance</u> Referral Source Name: <u>Bob's Pharmacy</u> (organization, not person) Referral Source Type: ☒ Doctor/health care Provider ☐ Hospital ☐ Health Clinic ☐ Religious Org. ☐ Human Service Provider ☐ School/Children's program ☐ Business ☐ Word of Mouth ☐ Libraries ☐ Govt/Public Agencies ☐ Our outreach material ☐ Event ☐ We contacted them ☐ Media ☐ Other ☐ Unknown																																																																																																
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 45%;">ID#: <u>2-4126</u></td> <td style="width: 5%;">00</td> <td style="width: 5%;">01</td> <td style="width: 5%;">02</td> <td style="width: 5%;">03</td> <td style="width: 5%;">04</td> <td style="width: 5%;">05</td> <td style="width: 5%;">06</td> <td style="width: 5%;">07</td> </tr> <tr> <td>RACE: Caucasian, African-Am, Asian, Hispanic/Latino, Native Am. Other, unKown (check all that apply)</td> <td><u>C</u></td> <td><u>C</u></td> <td><u>C</u></td> <td><u>C</u></td> <td><u>C</u></td> <td></td> <td></td> <td></td> </tr> <tr> <td>GENDER: Male, Female, UnKnown</td> <td><u>F</u></td> <td><u>M</u></td> <td><u>M</u></td> <td><u>M</u></td> <td><u>F</u></td> <td></td> <td></td> <td></td> </tr> <tr> <td>AGE or DATE OF BIRTH (month/ year)</td> <td><u>6/71</u></td> <td><u>4/68</u></td> <td><u>1/88</u></td> <td><u>2/92</u></td> <td><u>3/99</u></td> <td></td> <td></td> <td></td> </tr> <tr> <td>INSURANCE STATUS: Uninsured, Fully Insured, Partially Insured (based on their needs), unKnown</td> <td><u>U</u></td> <td><u>U</u></td> <td><u>U</u></td> <td><u>U</u></td> <td><u>U</u></td> <td></td> <td></td> <td></td> </tr> <tr> <td>IF INSURED- TYPE: Indemnity, HMO/PPO, Medicare (MR), Medicaid (MD), CMSP (C), COBRA, COMmonhealth, Unemployment, Community-based (CB), Other, unKnown, N/A</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>EMPLOYMENT STATUS: Unemployed, Fulltime, Part-time Seasonal/Temporary, Retired, , unKnown, N/A</td> <td><u>P</u></td> <td><u>P</u></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>INCOME SOURCE(S): Wages/Earnings, TAFDC, EAEDC, Unemployment, Soc. Sec (SS) SSI/SSDI (SI), Child Support, Vets Benes, , Pension, Other, unKnown, N/A</td> <td><u>W</u></td> <td><u>W</u></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>INCOME LEVEL FOR HOUSEHOLD</td> <td colspan="8"><u>\$ 30,000</u> per/ <u> </u> month ☒ year (check one)</td> </tr> <tr> <td>COST OF INSURANCE FOR HOUSEHOLD</td> <td colspan="8"><u>\$</u> <u> </u> per/ <u> </u> month <u> </u> year (check one)</td> </tr> </table>							ID#: <u>2-4126</u>	00	01	02	03	04	05	06	07	RACE: Caucasian, African-Am, Asian, Hispanic/Latino, Native Am. Other, unKown (check all that apply)	<u>C</u>	<u>C</u>	<u>C</u>	<u>C</u>	<u>C</u>				GENDER: Male, Female, UnKnown	<u>F</u>	<u>M</u>	<u>M</u>	<u>M</u>	<u>F</u>				AGE or DATE OF BIRTH (month/ year)	<u>6/71</u>	<u>4/68</u>	<u>1/88</u>	<u>2/92</u>	<u>3/99</u>				INSURANCE STATUS: Uninsured, Fully Insured, Partially Insured (based on their needs), unKnown	<u>U</u>	<u>U</u>	<u>U</u>	<u>U</u>	<u>U</u>				IF INSURED- TYPE: Indemnity, HMO/PPO, Medicare (MR), Medicaid (MD), CMSP (C), COBRA, COMmonhealth, Unemployment, Community-based (CB), Other, unKnown, N/A									EMPLOYMENT STATUS: Unemployed, Fulltime, Part-time Seasonal/Temporary, Retired, , unKnown, N/A	<u>P</u>	<u>P</u>							INCOME SOURCE(S): Wages/Earnings, TAFDC, EAEDC, Unemployment, Soc. Sec (SS) SSI/SSDI (SI), Child Support, Vets Benes, , Pension, Other, unKnown, N/A	<u>W</u>	<u>W</u>							INCOME LEVEL FOR HOUSEHOLD	<u>\$ 30,000</u> per/ <u> </u> month ☒ year (check one)								COST OF INSURANCE FOR HOUSEHOLD	<u>\$</u> <u> </u> per/ <u> </u> month <u> </u> year (check one)							
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QUICK INTERACTION- No Detailed Info Possible (use this sparingly! all info in Service Grid will be N/A if blank)																																																																																																

The Healthy Connections program used this tracking form for intakes of individuals. It was designed both as a tool for outreach workers as an easy vehicle for documentation for program evaluation.

*Note: Blank forms are available for reproduction in the "Steal This Section" at the end of this book.

SERVICE BACKGROUND	00	01	02	03	04	05	06	07
WITHIN LAST 12 MONTHS:								
Had Health Insurance? (Yes/No)	N	N	Y	N	N			
Visited a Physician? (Yes/No)	Y	N	Y	N	Y			
Didn't seek services because not insured? (Yes if didn't try)	Y	Y	Y	Y	Y			
CURRENTLY:								
Primary source of health care? (check one/ person)								
Private Doctor/group practice								
Neighborhood clinic								
Hospital Clinic								
Hospital Emergency Room	✓		✓		✓			
Other		✓						
None/ No Source of Regular Care		✓		✓				
Unknown								
N/A								
Barriers to Health Care? (all that apply)								
Can't Pay/ Too Expensive	✓	✓	✓	✓	✓			
Not Treated Satisfactorily Previously	✓	✓						
Can't Get There/No Transportation								
Limited Understanding/Use of English								
Information difficult to understand	✓	✓	✓	✓	✓			
Not eligible for anything	✓	✓						
Other								
None								
Unknown								
N/A								
What health needs do you have? (all that apply)								
Primary Care	✓	✓	✓	✓	✓			
Outpatient Services	✓	✓	✓	✓	✓			
Hospitalization	✓		✓		✓			
Prescriptions	✓	✓	✓					
Dental services	✓	✓	✓	✓				
Mental Health services	✓							
Specialty Care	✓		✓	✓	✓			
Other								
None								
Unknown								
N/A								

As part of the intake process, Healthy Connections outreach workers identified important background information. This information was helpful to further case advocacy. It also played a vital role in informing community and state policy.

In one instance, information was compiled to identify the need for a community-based dental center that accepted Medicaid on Cape Cod. This center was built in 2000.

**HEALTHY CONNECTIONS
MONTHLY SERVICE INFORMATION**

Worker Name: Joanne Smith Agency Name: _____ Month: Feb. Year: 2000 Completed: 3 / 6 / 00

ID # Household	Indiv	Service Action	Date Provided/ Achieved	Name of Program or Service	Type of Program or Service	Need or Comments
C-1234	02	Referral R Enrollment E Gained Service S Follow-up F Denial D Assistance A	When was service action taken or achieved?	What was the NAME of the program or service to which the person was referred, enrolled or served, etc.?	Indicate TYPE of program or service (ie. Medical, Housing, etc.) *LIST BELOW*	Reason for needing the service OR Pertinent comments
Z-4126	00	R	2/3	Medicaid	HC	uninsured, works p/t thyroid condition
	01	R	"			uninsured, works p/t
	02	R	"			asthma
	03	R	"			
	04	R	"			infant
Z-4126	00	F	2/7			Faxed income verification
	01	F	"			(for both - Baby in hospital!)
Z-4126	00	D	2/14			
	01	D	"			
	02	E	"			
	03	E	"			

Program/Service Types: Health Insurance/Coverage (HC), Medical Services (M), Prescriptions (P), Dental (D), Vision (V), Childcare (C),
Housing (H), Education/Training (E), Transportation (T), Substance Abuse Services (S), Food Assistance (F), Legal Services (L),
Financial/Credit Assist (FC), Parenting Support (PS), Domestic Violence Services (DV), Other Services (O)

Page ___ of ___

The Monthly Service Action form documents the actual services provided by outreach workers to all individuals during a month. This information documents the range of services and the amount of services provided by each outreach worker; it is then included in a program-wide database. The basis for this information is captured by a similar form outreach staff use to track an individual's case; that form remains in their confidential case folder.

**HEALTHY CONNECTIONS
MONTHLY OUTREACH SUMMARY FORM**

Worker Name: Joanne Smith
 Month: Feb. Year: 2000

Agency Name: _____
 Date Completed: 3/6/00

NUMBERS SERVED (UNDUPLICATED)

	Households Served	Total People Served	New People Served (first-time contacts)
TOTAL This Month	<u>28</u>	<u>56</u>	<u>23</u>

TOTAL SERVICES PROVIDED

Add figures from same chart on OW's forms

	Households	Total People	NEW People Served (first contacts)
Referrals Made	<u>9</u>	<u>56</u>	<u>23</u>
Enrollments Occurred	<u>11</u>	<u>31</u>	<u>12</u>
Services Received	<u>7</u>	<u>13</u>	<u>12</u>
Follow-up Contacts Made	<u>17</u>	<u>44</u>	<u>15</u>
Denials of Referral Occurred	<u>1</u>	<u>2</u>	
Assistance Provided (no referrals made)	<u>7</u>	<u>8</u>	<u>6</u>

Key: Use your Monthly Service Info form to get this information
 For Households: If a household has an R,E, etc. it is counted as 1 (ex. Add all households that include an R)
 For Total People: Add up the R's, E's, etc. (ex. Add up every R you see to get Referral total)

The Monthly Summary form provided a vehicle for both the outreach worker and supervisor to get a snapshot view of the month's activities and to make reporting of data easier. Of note is the "New" column that allows for calculation of unique individuals served during the month, as opposed to the many return clients who were served.

COMMUNITY CONTACTS MADE BY YOU			
Type of Contact	Name of Group	Type of Group	Who Contacted AND What Purpose
2/4	Ice cream social	Immigrants + refugees	Outreach table for new arrivals
2/10	Elementary School	Immunization Day (school nurse)	School kids: families needing free immunizations
2/16	Health Care Advocacy Task Force		(monthly meeting)
2/14 - 25	Radio station	- Public service announcement x 70	Talk show listeners

Key: Medical Providers (M), Human Service Providers (H), Schools/Childrens Programs (SC), Religious Orgs (R), Govt/Public Agencies (G), Business (B) Libraries (L), Events (E), Media (M), Other (O)

WHAT DO YOU SEE THAT WE SHOULD KNOW?

- Community issues regarding gaps or services that should be highlighted
- Examples which capture the service needs of people you've worked with.
- Examples of the positive effects of the program in bringing services to them
- Success stories /Examples of the positive effects of the Program
- Changes in the community (or our program) in policies, practices or programs

- Many working parents in this area are losing coverage through their employers
- Brought interpreter to immigrant outreach; able to complete applications for three new families!

Isaac Smith
Outreach worker Signature

3.6.00
Date Completed

The Monthly Reporting Forms also seek to capture the qualitative activities of outreach staff, a significant element of their work. Outreach and enrollment require both formal and personal contacts for marketing. This form also provides a place for outreach workers to identify issues they see at the community level, often the best early-detection system regarding health access issues.

CHAPTER 5



Making Outreach Work

The specific community-based outreach strategies provided in this chapter were gathered from outreach workers across the state of Massachusetts over a period of more than one year. They include basic approaches for outreach, ideas about who to work with, and an array of best practices--some of which may surprise you.

We offer these strategies to be tried in your communities. We have learned that certain strategies work in some places and not others because communities are not the same. However, we believe that some of these strategies will work to advance outreach and enrollment in your community.

This chapter includes:

Making Outreach Work

Approaches to Outreach

Potential Partners

Best Practices for Outreach

Making Outreach Work

Outreach is an essential and powerful component of any effort to expand health care coverage and increase access to health care. State and federal agencies can create policies that provide opportunities for broader health care coverage. Encouraging people to enroll in these programs and use services is a challenge. Enrollment and increased access often occur on the grassroots level through community-based outreach efforts and individual contact.

Outreach is not new and doesn't need to be complicated, but it can be done either well or poorly. Effective outreach requires knowing the community and being creative, trustworthy and very determined. Outreach is based on knowing where to go, how best to communicate a message so that it is heard, and being able to serve as an effective, reliable source of information and support.

The Best Practices identified in this section are grouped into three categories: Approaches to Outreach; Who to Work With; and Distinctive Outreach Strategies. These have been garnered from community groups throughout Massachusetts (and elsewhere) that work successfully on issues of health care access. No single practice or approach can work for all communities, but the broader the repertoire of options, the greater the chance for success.

Approaches to Outreach

- Meet people "where they are at"
- Be respectful
- Listen to your community
- Build trust and relationships
- Get the word out in a non-stigmatizing manner
- Offer services and information in a variety of locations (including home visits) and at non-traditional times, especially after work hours
- Make written information friendly and easy to understand
- Provide information in the primary language of those you are serving
- Follow-up, follow-up, follow-up!

Potential Partners

It is critical that you find people and organizations to work as your allies. Identify their motivations (how they will “profit”) and work to develop win-win partnerships.

- **Community leaders**—both those with formal roles (like a school principal or religious leader) and those in informal positions of influence due to their standing in the community (such as a neighborhood person everyone seems to go to for advice)
- **Hospitals** (including emergency rooms)
- **Health centers** (including office staff such as medical secretaries)
- **Doctors’ offices** (including office staff and billing managers)
- **Billing agencies** that serve medical providers
- **Health-related clinics** (such as immunization, blood pressure, smoking cessation)
- **Visiting Nurse Associations** (VNAs)
- **Schools** (school nurses, counselors, and health coordinators). This often requires the initial support of the superintendent, principal, or PTA
- **“Satisfied customers” of your services.** Word-of-mouth is the best source of referrals
- **Churches, synagogues, mosques, temples and other places of worship**
- **Child-care centers and home day-care** (including “unofficial care providers”)
- **Housing authorities**
- **Courts, police and public safety departments**
- **Pharmacies**
- **Local businesses and employers** (especially small businesses, retail chains, restaurants and “temp” agencies that often offer limited or no health benefits)
- **Local agencies or local offices of state agencies** which provide services to people who might be eligible for health-care coverage or have an interest in seeing people get health coverage (including local boards of health or WIC and Head Start for children)
- **Programs for those in need** shelters, job training programs, literacy programs
- **Local media** (print, radio, TV, billboards)

Best Practices for Outreach

Every community is different. What works well in one community may not in another. Factors that seem to impact success include: timing; credibility and sensitivity of outreach staff; how the outreach effort is organized and publicized; and the local culture and attitudes. People need to hear about your program and efforts from several different sources before they will contact you.

Use word-of-mouth

The best source of a referral is someone who was helped and thought the service you offered was good. People trust those closest to them for advice on where to go. Getting “word of mouth” referrals is a true indication of a program’s penetration into a community. Encourage “satisfied customers” to tell their friends and relatives.

Use a “loss leader”

Offer a service, an item or information that will attract people to contact you and provide an opportunity to talk about health coverage

Provide non-stigmatizing medical or health-related services for people in the community (such as preventive health screenings, prescription assistance or low-cost doctors’ visits) as a way of bringing you in contact with people who would otherwise stay away. Once a relationship is developed, screening for enrollment is possible.

Identify and target “gatekeepers” who affect recipients’ abilities to enroll/gain access services

In rural areas, for example, fathers are often seen as “gatekeepers” for the entire family. If they say “No,” no one in the family gets health insurance. Several programs direct outreach to fathers, mothers, grandparents or teens—all of whom have been identified as gatekeepers/decision-makers.

Hold raffles at community events

Raffle off a desirable item as a way to collect names of people interested in getting more information about health access or simply to engage people in discussion. Anyone is eligible to participate in the raffle if they fill out a short questionnaire that asks if they have health insurance and if they want to be contacted with more information. Items that have been raffled include a fully stocked toolbox and a color television. Raffles have been set up at community fairs, Little League games, etc.

Place inserts in local/regional newspapers

Distribution of inserts/flyers in local papers is cost effective and allows for broad distribution. They reach many people who would not otherwise see your material, in a non-stigmatizing manner—everyone gets it in their paper. This is especially effective when using the free newspapers that exist in many communities.

Place inserts into utility bills

Use the distribution capacity of gas, electric or phone companies by having flyers inserted in their bills. This gets the word out to many households. This is a non-stigmatizing communication and can be low-cost or free.

Be creative and interactive at health fairs/community events

Health fairs and community events are common places for outreach efforts, but they have mixed results. To increase effectiveness, provide incentives for people to take information, fill out a questionnaire or complete an application. This may include raffles, small gifts for children/adults, or children's activities. Have unusual, attention-getting table displays or have staff wear costumes or eye-catching attire, such as T-shirts saying, "Need free or affordable health care? Talk to me."

Staff tables at job/employment fairs (as opposed to health fairs or civic events)

Unlike health or community fairs, job fairs are oriented toward people looking for work. This different focus tends to draw people who may not attend other types of fairs and who may be eligible for health coverage. Job fairs also offer a setting not directly associated with one's neighbors, so those people you engage feel more free to seek information and/or speak with you.

Sponsor everyday activities in the community

There are activities or functions that are so commonplace that they are often overlooked, yet they reach many people in your target group. Sponsor "snow day" announcements on the radio or television during winter months, for example—every parent listens/watches these on storm days.

Sponsor local sports activities

Community sports involve many people. Sponsoring advertisements through Little League or the local bowling alley will reach many families and youth.

Use existing programs for children to expand your capacity

One group doing outreach asked local businesses or institutions providing children's programming, like ballet and karate schools, to put a sticky label on all their registration forms. The labels encouraged parents to call for more information about health coverage. Pre-printed labels are easy to supply and a minimal hassle for those agreeing to use them on their materials.

Attend immunization days

Do outreach when school children receive their immunizations. Often those who come in to get required immunizations are the same children who lack coverage.

Contact child-care providers

Child-care providers would prefer to have children in their care with health coverage in case of medical emergencies. Contact providers and give them enrollment information for the children they serve. As with other low-paying, benefit-poor jobs, child-

care providers may not have insurance for themselves or their children. Ask about their own families once you've established contact.

Provide information to local police

Local police come in contact with many people who may need health insurance. When responding to domestic violence scenes, for example, many police are required to leave information with the victims regarding service options. Victims of domestic violence (mostly women) are known to stay in these situations because of financial dependence, including the need for health coverage for themselves or their children.

Offer trainings for doctors and their office staff

Put together a pleasant experience like a luncheon or coffee for local providers—or more importantly, their office managers/medical secretaries—to alert them to your program and inform them about eligibility issues/enrollment procedures.

Use pharmacists as allies

Pharmacists are often on the front line for knowing who has health care needs. Encourage pharmacists to post flyers/information on their counters or distribute them to those they serve, and/or set up an information table at a local pharmacy.

Seek out audiences likely to be eligible for health insurance

Find those with a high likelihood of being eligible for health coverage due to their participation in other programs, and contact them through mailings, door knocking, or phone calls. These may include self-pay individuals at the emergency room, households using fuel assistance or receiving subsidized child care, employees at companies with low-paying jobs (such as day-care providers and nurses' aides) or large companies that offer less-than-full-time jobs with few or no benefits.

For groups whose identities must remain confidential and are not directly accessible to you, be creative within the necessary limitations. With children in school lunch programs, for example, provide the staff overseeing the program with prepared information on health coverage and ask them to distribute as they see fit.

Use commercial mailing services to reach your community

Val-Pak coupon mailings reach thousands of households at a reasonable cost. Company staff often assist with details like layout of your insert.

Work with medical billing services

Get inserts/flyers to billing services that collect for doctors' offices. They can insert these in mailings to families known to be without insurance. This can be very powerful since it is in the billing company's interest to see that bills are paid.

Provide trainings in "temp" agencies

Frequently people working for "temp" agencies are hourly employees with no benefits. Providing information to the agency may help them retain employees.

Outreach to the prison population

Outreach to pre-release inmates in correctional institutions requires special permission, but it can be effective. Individuals scheduled for release are often in need of jobs, housing and health insurance. For certain programs, especially those with inroads to a correctional institution, this can be a very good form of outreach.

Advertise on milk cartons

Many people buy milk, and the sides of cartons offer a good, local form of advertising.

Distribute or conduct a health care survey

Surveys regarding health needs or insurance coverage provide a vehicle for communicating with individuals or households. You can distribute the surveys in schools, at community events or one-to-one on the street. Keep questions simple and request contact information for follow-up.

Facilitate the enrollment process with portable electronics

Technology can be a helpful tool. Most people are understandably unwilling to give up their original documents (birth certificates, pay stubs etc.) for the enrollment process. Portable scanners, copiers or digital cameras are increasingly affordable ways of capturing information during an outreach visit or presentation. You can bring a cellular phone with you to provide immediate access to enrollment systems, to track down a contact or to make an appointment.

Use children's artwork in your promotional materials

Often fun and eye-catching, children's artwork uses unconventional language and has community appeal.

Create display windows in prominent areas

Get a display window on a well-traveled street, at a popular gathering area, or in a bus depot and put your information there to be seen.

Advertise on local billboards

Billboards showing local people and/or phone numbers located in high traffic areas can dramatically increase awareness.

Offer a toll-free telephone number

Especially in rural and/or large service areas, 800-number service increases an individual's ability to call without long-distance phone costs. This can also be helpful in bringing awareness to your program: "For health coverage assistance, call 800-XXX-XXXX."

Send information home with report cards

Parents generally see report cards. Work with local schools to send flyers home with children's report cards or other "must see" school communications.

Place flyers or stickers on school registration materials

At the beginning of the school year, parents receive information and fill out emergency contact cards. Attaching stickers with your program's contact information to key informational material or emergency cards, or sending home a flyer as part of the official school packet, provides an excellent opportunity for broad distribution.

This is also a good time because parents are already thinking about insurance, since many schools ask for health insurance or medical emergency information. (As above, this requires preparatory work with schools, beginning in the summer.) Ideally, convince the school to add a line to their registration forms asking, "Do you have health insurance?" Follow-up can be done directly by school nurses. Your program's information or a referral can then be made to each family as appropriate.

Attend kindergarten registration in spring/summer

All kindergarten children need to sign up prior to attending school, often at a set period in each community. Being at these sessions with information about your program is a good way to meet with parents. (In some instances, they may even be there without their children, providing a rare opportunity to talk without distractions.)

Advertise on radio and cable TV stations in your community

If an outreach program knows its target community, it will know where they seek entertainment and news. Many communities or ethnic/cultural groups may have preferred radio and TV stations that can provide a credible and concentrated venue for your message.

Provide info in welcome packets to new residents or parents

Use the idea of the community "Welcome Wagon." Make contact with new residents in the community and provide them with your information. Try this with new parents who may need health coverage for their child and/or themselves.

Place information on store/ATM receipts

Advertise your services and spread your message by having them placed on the back of supermarket/store or ATM receipts. These efforts can be affordable and targeted.

Use businesses that distribute products in the community

Get flyers/inserts in supermarket shopping bags or in take-out food containers, such as pizza boxes. These get to many people throughout the community in a non-stigmatizing manner, at low cost to you.

Video stores

Work with retail store managers to provide health insurance information with every child-oriented video that is rented.

Pledge cards

Develop pledge cards to be distributed at events, asking people to commit to health access goals. As part of the pledge process, include questions about their household's insurance status and their interest in getting additional information.

House parties

Offer incentives to people to host a house party at which health access information can be discussed and enrollment can occur. Guests can participate in a raffle for a gift.

Advertise in restaurants

Place your program's message on food tray liners or paper placemats at restaurants. This provides a non-traditional context for getting the message to many people on an individual basis. For a minimal cost, many people can learn about your program or their eligibility in a non-stigmatizing and potentially fun setting.

Distribute flyers in back-to-school shopping bags

Take advantage of seasonal or natural activities like "back-to-school shopping." (Depending upon the size of the store/chain, this might require approval from a central office.)

Provide trainings and information within the court system***(Especially divorce court and victim assistance programs)***

People—primarily women—participating in divorce court proceedings are concerned about health insurance coverage for their children, either because of an anticipated drop in income or because insurance was available through their spouse. Making information available to divorce-court clerks is an important link. Similarly, information about affordable health-care options is often a high priority for those seeking help from victim-assistance program, especially women with children who are considering leaving abusive relationships.

Post flyers with tear sheets everywhere possible around town

Flyers are a mainstay of outreach. Providing "tear-offs" (tabs on the bottom of the sheet that people can tear off and take with them) is most effective. Post flyers everywhere: laundromats, bus stations, grocery stores, libraries, thrift shops, campgrounds, playgrounds, town halls and other public gathering sites.

Hit the streets, talk with people one-on-one

Go to where people live, congregate and shop; engage them one-on-one. Establishing this contact is hard, but it works. There is no substitute for being out in the community and meeting people. Good places to go include supermarkets, laundromats, libraries, parks, and community events.

Hold off-hour/weekend coffees

Create a low-key gathering by offering informational coffees in towns and neighborhoods. These are best held on weekends and evenings. They can be held in town halls,

places of worship or other natural gathering places. This works well for programs with small budgets and/or large service areas.

Work with local agencies—let them know you can help

Many community social service agencies are overwhelmed and understaffed. Contact these allies and let them know that you can help their clients and patients with enrollment and access to health care. Emphasize that you are there to help rather than make more work. Post your flyers at their sites for consumers and staff to see. If you have time, do a training for their staff and leave behind informational materials.

Encourage agency staff to incorporate health-care information and enrollment as part of their daily work

Find and promote allies in your agency or other agencies who do not work on health-care access but who regularly deal with people who might be eligible for health coverage. Consider creative ways to motivate these staff to incorporate health-care information or enrollment in their daily work.



Section III

The Health Access Networks: Supporting Community-Based Outreach





CHAPTER 6



Why Health Access Networks?

The model identified in this chapter is the Health Access Networks (HAN) developed in 1998 to assist and support community-based organizations doing outreach and to promote community-based outreach generally.

This chapter will focus on the necessary support systems for community-based outreach programs.

This chapter includes:

Why a Health Access Network for your Community?

Article: What's Working for Children's Health: Case Study

At A Glance



Why a Health Access Network for your Community?

Enrolling people in the expanded Medicaid and newly developed CHIP health-care programs takes effort from a cadre of people: community-based outreach workers, state agency workers and managers, advocates, and many others. To make our efforts most successful, we need to coordinate activities statewide.

We all benefit from staying connected to each other, learning from each other and problem-solving issues together. The Health Access Networks (HAN) can enhance your state's outreach and enrollment activities by coordinating outreach statewide. Here are some of the problems and challenges addressed by the Health Access Networks:

Information on programs and policy changes

With states continuously expanding eligibility and coverage for their residents, programs can change on a daily basis. State eligibility workers, community-based outreach workers, and others need current information on programs they are 'selling.'

Knowing who to call for help, advice and information

We all need to know who to call for tough cases, exceptions to the rules, or strategies to make our jobs easier. At HAN meetings, communities meet state workers who can help them problem-solve. As one outreach worker stated, "There are so many difficult cases... I'm glad we have these meetings so I can figure out who to go to next."

Relationships with outreach peers

We all need to know that we're not alone in our efforts. A HAN participant noted that "The meetings seem to come right when I'm feeling overwhelmed and I need support and new ideas. When I leave a HAN meeting, I feel energized and ready to go again."

Knowing best practices

Outreach is based on knowing where to go, how to best communicate a message so it is heard, and being able to serve as an effective and reliable source of information and support. It is also based on innovative strategies, otherwise known as best practices. At HAN meetings, people are encouraged to share—and steal—promising practices. We call it outreach larceny, and it works!

Avenues for policy change

No matter where you sit—in a community-based organization, state agency or hospital emergency room—we all need ways to advocate for policy change on issues of common concern. The statewide advocates at HAN meetings can help direct us toward positive action to make health care more accessible.

“What’s Working for Children’s Health: Case Study”

Ana Hicks, *Sign Them Up!*, Children’s Defense Fund, May 1999

Health Access Network in Massachusetts

“Attend kindergarten sign-ups in spring/summer, put flyers in back-to-school shopping bags, and include a message on food tray liners at fast food restaurants or on paper place mats at restaurants.”

These are just a few of the distinctive outreach strategies gathered from community groups by the Health Access Network (HAN) in Massachusetts. HAN was established by Area Health Education Center (AHEC)/Community Partners in Amherst, Massachusetts to provide community-based organizations working on health care access with an opportunity to exchange policy information, share best practices, and build a relationship with state agencies. The Division of Medical Assistance (Massachusetts’ Medicaid Department) provides funding for HAN through the University of Massachusetts Medical School. HAN hosts five meetings per month in five separate regions throughout Massachusetts.

HAN Moves Beyond Original Goal

In hopes of engaging and enrolling uninsured families the state has previously been unable to reach, Massachusetts awarded 52 mini-outreach grants in 1998 to community organizations in amounts ranging from \$5,000 to \$20,000. The state mini-grant recipients include housing groups, child care agencies, mental health agencies, clinics, hospitals, homeless groups, health centers, immigrant and refugee service organizations, and community coalitions.

The original goal of HAN was to maximize coordination among the grant recipients to help them become even more effective in their efforts to reach uninsured families. As a measure of their success, the monthly meetings have also attracted other organizations that did not receive mini-grants, but are working on health access issues within the state.

Over the past year, additional community groups and health care advocacy organizations have started attending the HAN meetings. Currently, about one-third of the participants in these monthly meetings are from groups which are not mini-grant recipients. Just like the grant recipients, these groups find the exchange of information to be extremely useful in furthering their efforts to enroll uninsured families, and

they appreciate a chance to voice their concerns about health access to representatives from the state agencies. Attendance at these meetings varies from region to region, with an average of 30 to 35 participants. However, in the Boston area meetings have attracted as many as 70 participants.

Running a typical HAN meeting

Every HAN meeting has three core components: 1) community updates; 2) exchanges with state agencies; and 3) reports on statewide policy issues.

Meetings always begin with community updates from the various attending organizations. Each community group is given the chance to explain what is working and not working within their community. Through this process, people share and receive best practice ideas and begin to address the barriers they, and the families they work with, are facing.

The second part of the meeting is devoted to the state agencies. Representatives from the Department of Public Health and the Division of Medical Assistance provide the group with their own updates, such as enrollment numbers, new policies, or progress in changing or updating state policies. Following the update, community groups participate in a question and answer session.

At the end of every meeting, the statewide advocacy organization, Health Care For All, provides an update on the big policy issues at the state level. They give the group information about changes in pertinent legislation and regulations that impact their work.

HAN Participants Find Meetings Effective

According to a HAN survey conducted in October and November 1998 and completed by 126 HAN participants, four out of five respondents said that HAN has been effective in helping them promote health access in their communities. One HAN participant reported, "It is helpful to meet with others to keep updated and not feel like you are doing outreach in a vacuum." Another participant explained, "HAN provides an excellent environment for expanding knowledge and access to health care services."

Another indicator of HAN's success is that participation in the meetings has remained steady and has extended beyond the mini-grant recipients. According to Ellen Unruh from AHEC/Community Partners, "All of our expectations [about HAN] have been exceeded."

For more information about HAN, visit the AHEC/Community Partners web site at <http://www.ahecpartners.org/hca>, or call Ellen Unruh, Program Coordinator, or Michael DeChiara, Program Director, at (413) 253-4283.

At A Glance

Goals of the Health Access Networks

- Exchange information about changes in programs or policies
- Share promising practices for outreach/enrollment
- Serve as a link between communities and state agencies

Program Functions of the Health Access Networks

- Support community-based outreach and enrollment efforts
- Promote statewide health access initiatives and coordination
- Advocate for policies which expand health access and increase enrollment

What Coordination Can Create

- Information on programs and policy changes
- Knowledge of who to call for help, advice and information
- Relationships with outreach peers
- Awareness of best practices

CHAPTER 7



What Is a Health Access Networks Meeting Really Like?

A fundamental principle of HAN is that the key stakeholders need to work with each other to support effective outreach and enrollment efforts.

The Health Access Networks meetings are safe places in which people who care about health care access can meet in the same room on a regular basis to communicate and, we hope, collaborate.

This chapter will address the texture and content of the Health Access Network meetings.

This chapter includes:

What Is a Health Access Networks Meeting Really Like?

3-Way Dynamic of a HAN Meeting

HAN Meeting Components

Sample Agenda

Sample Minutes

Who Attends HAN Meetings?

By the Numbers

At A Glance



What Is a Health Access Networks Meeting Really Like?

It's the first Friday of the month, time for the monthly Western Massachusetts Health Access Networks meeting. At 9:30 am, an AHEC/Community Partners staff person heads over to the local library to set up the meeting room. The room is large, pleasant, well-lit, and 40 chairs are set up in a circle. An agenda and resource materials are placed on each chair. Coffee and pastries are delivered to welcome the participants.

By 9:45, a number of participants have arrived, happily greeting familiar faces and welcoming new ones. Many of them have gathered ten times a year for the last three or four years. They have grown familiar and fond of each other.

By 10 o'clock, there are 25 or more people in the room, and it's time to get started. The convener asks participants to take their seats. This can take a while, as many of the them are engaged in exchanges and updates with friends and colleagues.

After the official welcome, the convener asks for introductions, and each person in the circle states his or her name and organization. Represented in the room are community groups, state agencies, consumer advocates, and other health access stakeholders.

The communities represented come from the western third of the state, from towns bordering Connecticut, New York and Vermont to cities closer to central Massachusetts. These communities are quite different in makeup, despite their geographic proximity. The range includes rural, primarily poor white communities, urban African-American and Latino neighborhoods, college towns, and farming communities. As different as the communities and the outreach workers representing them are, participants readily exchange ideas and learn from each other.

Following introductions, the agenda is reviewed and contents of the meeting packet are highlighted. Then it's time for community updates, a chance for people to share what is new in their communities and what they have done or observed since the last meeting that they would like to share with the group.

Outreach workers from each of the communities take turns sharing successes and failures. This month, outreach workers have participated in community health fairs and a health center-sponsored "community baby shower." One group shared a video spot they had run on cable TV. Others passed around flyers they found to be very effective. Throughout this portion of the meeting, there were questions about each of the events or outreach strategies, such as the cost of production and airing of the video spot and what outcomes had emerged.

The news is not all good. The outreach workers talk about their frustration about those for whom they can find no coverage, or problems that persist due to system glitches or bureaucratic difficulties. The state agency representatives don't respond defensively to these case stories, but instead inquire, make suggestions, offer to follow up, and make plans to discuss the cases after the meeting to further problem-solve.

When issues are identified that cannot be resolved by those at the HAN meeting, participants know that AHEC/Community Partners will bring them to meetings with the "central office" management of the state agencies, where systemic problems are put on the table and addressed. Results of these discussions are ultimately reported back to the HAN.

As community sharing continues, another group talks about the enormous frustration they have experienced when a state agency made errors processing an application form, or acted inappropriately in dealing with their clients' cases. They also mention how wonderful a specific outreach worker at the state agency's local office has been in helping to solve the problems. This is often some of the first positive reinforcement that the state workers have ever received from community outreach workers, and it helps solidify a bond between them.

After community updates, the convener has the group consider a theme that is being considered at the other Health Access Meetings across the state. It has become apparent that the issue of mental health access should be looked at, since it has come up in several different HAN meetings over the past few months. The convener asks everyone in the room, regardless of what hat he or she wears, to share his or her perspective on mental health access.

Twenty minutes are set aside to solicit comments and observations on this issue. The discussion quickly ignites as cases and gaps in the system emerge from around the room. Outreach workers talk about difficulties their clients have faced trying to fill prescriptions after hospitalizations or get appointments for outpatient mental health care, especially for the uninsured.

There is also talk about what is working in the system. The group agrees that those insured through Medicaid, for example, have adequate access to outpatient mental health services—this is a success. The discussion ends with a promise to return to it for closer examination in the coming months, after similar discussions have taken place throughout the state and an appropriate course of action will be more clear.

The spotlight now turns to the state consumer advocacy group, which regularly has up to 30 minutes on the agenda. The advocate representative gives an update of what is happening in the state on a broad range of health care and health access issues. This month, she covers progress being made in the state budget process, and developments regarding publicly-funded health care programs. These programs assist children, seniors and disabled with prescription needs, and the Medicaid/CHIP-eligible populations.

Midway through the discussion, an outreach worker reads a letter she received from her state legislator. It was a response to the letter she wrote advocating for a health access program. She encourages all in the room to write to their legislators.

During the consumer advocate section of the meeting there is also discussion about the recent HMO crisis and developments regarding bailout of a prominent non-profit HMO in the state. An advocate for the elderly raises the issue that despite the state bailout, there is a lack of Medicare HMOs in rural areas and the needs of seniors in the western part of the state have been overlooked. There is need for state legislation to include consumer voices in HMO operations.

Finally, there is a short presentation on the findings of a governor-mandated dental commission about the terrible state of oral health access in Massachusetts. The advocate thanked the many participants who attended community meetings to provide input to the state commission. The group knows dental access is a huge problem and continues to push for changes in Medicaid reimbursement rates and other solutions.

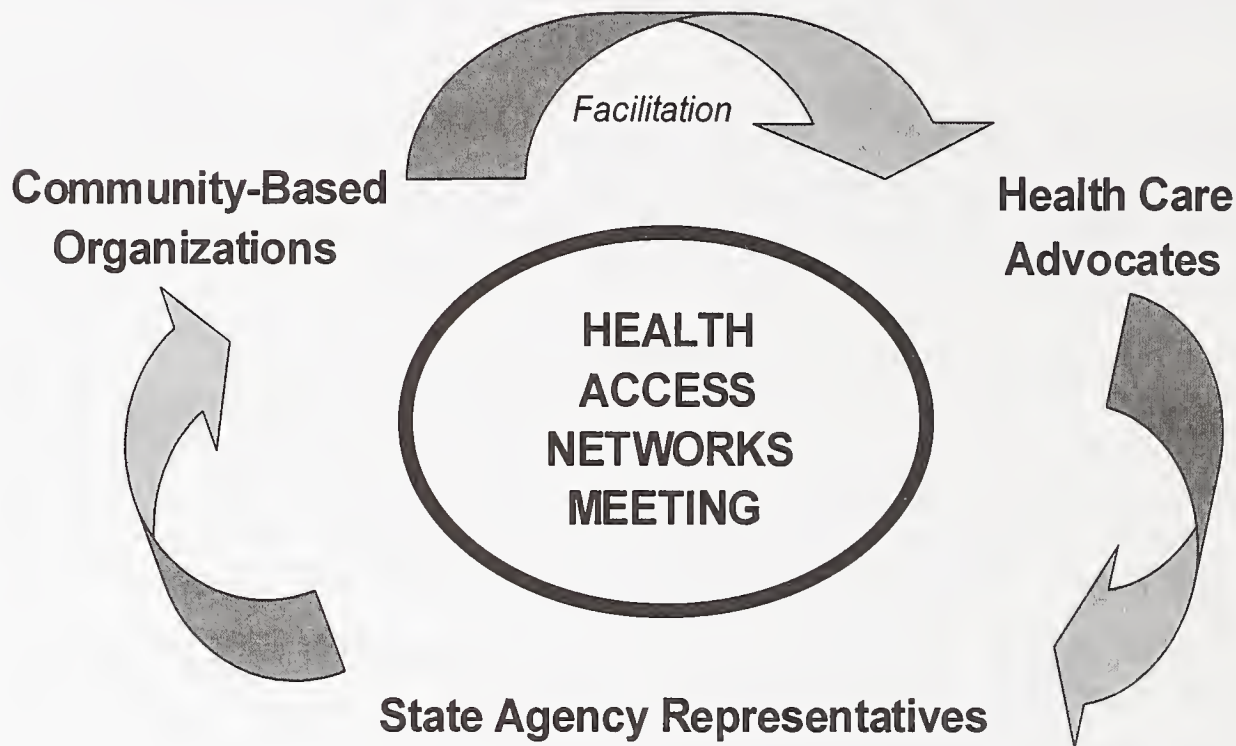
The last half hour of the meeting turns to the state agency representatives, who give updates on their health care access programs. They answer questions and concerns posed by others in the room. The vendor for the Medicaid agency provides a brief on a new program that seeks to expand coverage by engaging small employers. A lively exchange ensues with outreach workers who are on the front lines for promoting these programs about what they are seeing (which in this case is limited success).

The regional staff person for the state health agency shares current enrollment data for a state-funded children's health insurance program. She also reminds outreach workers that public health office staff can provide multilingual phone support for the enrollment process, and additional follow-up for complex cases if necessary.

As the meeting comes to an end, the date of the next meeting is confirmed. Announcements are made about special themes and guests for next month. The group decides that a representative from a statewide immigrant advocacy group will be invited to offer her expertise on a range of issues concerning health access for immigrants and refugees.

The two-hour meeting ends on time. Staff and volunteers fold up chairs as small groups mingle and chat for the next 20-25 minutes. This is a chance to follow-up on comments and issues that arose during the meeting, to share contact information, and to ask more questions or share ideas. Participants grab a last cup of coffee before driving home (for some, this takes an hour or more), only to return in 30 days to meet once again.

3-Way Dynamic of Health Access Networks Meetings



Health Access Networks meetings are based on equal participation by the three key stakeholder groups: community-based organizations, state agency staff (regionally based is preferable), and health care or consumer advocates. Each group has a chance to present during the meetings and is encouraged to ask questions of other participants. The meetings provide unique opportunities for them to appreciate each others' respective roles in the health access landscape.

HAN Meeting Components

Agenda Components

- Community updates
- Exchange with state agency representatives, with time for questions and answers
- Statewide advocacy group updates, with time for questions and answers

Sample Meeting Topics

- Program changes and expansions regarding eligibility and procedures for Medicaid or CHIP
- Identification of health care coverage gaps (such as dental, mental, prescriptions) on both the statewide and community-levels, and discussions of initiatives to address these.
- Sharing of community outreach efforts
- Consideration of cultural awareness and cultural competency when doing outreach and enrollment



HEALTH ACCESS NETWORKS

A Program of AHEC/Community Partners
24 South Prospect Street, Amherst, MA 01002
Tel: 413-253-4283, Fax: 413-253-7131
Website: www.ahecpartners.org

NEW on our web site:
**Kaiser Family Foundation Report
on the Uninsured in America**
&
**The Oral Health Crisis in
Massachusetts: Report of the Special
Legislative Commission on Oral
Health**
www.ahecpartners.org

"I am proud of what we have accomplished to expand
health care access in Massachusetts."

*Mark Reynolds, former Acting Commissioner of the
Division of Medical Assistance, in a letter to HAN
participants, May 24, 2000*

Health Access Networks Western Massachusetts Meeting

Jones Library - Amherst
Friday, July 7, 2000
10:00 AM - Noon

AGENDA

- 10:00 a.m. Welcome & Introductions
- 10:05 Community Updates/Announcements
Other Participant Updates/Announcements
- 10:30 Health Care For All Update
 - Budget update
- 11:00 Exchange with the State Health Agencies
 - Division of Medical Assistance
 - Department of Public Health
- 11:20 *Special Presentation: Making the Intersection between Immigrants and Health Care*
Mercedes Perez, Massachusetts Immigrant & Refugee Advocacy Coalition (MIRA)
How to read immigration documents, Advocacy, Resources, Q. & A.
- 12 Noon Adjourn

*Next meeting September 8th, 2000 10:00 a.m.- Noon
Followed by Outreach Worker Lunch noon to 1:30 p.m.*
Questions? Call AHEC/Community Partners at 413-253-4283

An agenda is developed in the weeks prior to each meeting. While topics and special themes are coordinated statewide for all the Health Access Networks meetings, each region has individual needs from time to time. Agendas are mailed out two weeks before the meeting date with a copy of the minutes from the previous meeting. Starting and ending meetings on time is a priority.

Sample Minutes from a Health Access Networks Meeting

All names and organizations except AHEC/Community Partners and Health Care For All are composites

SAMPLE HEALTH ACCESS NETWORKS MEETING MINUTES

Tom Wolff, the convener, welcomed all to the meeting and gave a brief run-through of the agenda and the contents of the information packet, which included a handout on the upcoming Mini-grant deadline, a letter from the Milltown nurses' strike headquarters, and recent local, state and national news articles on health access. He offered copies of a new Directory of state agency and advocacy contacts to participants. He then asked participants to introduce themselves and their organizations.

COMMUNITY UPDATES

Jim Smith, ABC Health Care ABC Health Care has been conducting an intensive outreach campaign with the Insurance Partnership (a program of the Division of Medical Assistance that offers partial health insurance subsidies to employers and employees of small businesses). 14,000 flyers were circulated in local newspapers, co-coordinated with TV ads featuring State Representative Bob Darnley, over a 2-week period, generating two news articles in local papers. 600 small businesses received direct mail and 73 responded; enrollments are still in process. Jim said that many businesses have recently experienced a 20% -25% increase in insurance premium costs.

David Goodman, Senior Action Council The Senior Action Council is staging a health care rally on Wednesday, April 26th at 1:30 P.M. at the Arnold Community Center in Anytown. Congressman Oliver Johnson will be present and there will be a live video hook-up to Senator Kelly in Washington, D.C. The four goals of the rally are to support: 1) The addition of a prescription drug benefit to Medicare; 2) The state Pharmacy Program; 3) The availability and credibility of the Canada Rx Website as a less expensive source of brand-name drugs; 4) Northeast regional legislative meetings to investigate bulk prescription drug purchasing as a way to achieve more price equity with Canada.

Alicia Martinez, Salud Latina, Inc. Salud Latina has been using the Continental Channel, a Spanish-language channel, to let local small businesses know about the Insurance Program. Flyers with pull-off phone numbers at the bottom continue to be very popular. Salud Latina is also setting up a small community market as part of its site, to give small start-ups a venue to do business. People who may have been hesitant to start their own businesses can see that community marketing support is available to them, as well as financial support for self-employed people through the Insurance Program.

Aidan Day, Community Health Center of Washington County Aidan described the health information and self-care tip sheets on Colds and Flu, Emergency Contraceptives, Sinusitis and Cholesterol that the Health Center, through a Mini-Grant from Community Partners, had had translated into Spanish, Russian and Chinese. The University Translation Center did the translation work for around \$50/sheet, and did a great job reproducing diagrams and graphic formatting as well. Copies of all four info sheets in all three languages and English are available by calling Community Partners at 413-253-4283.

 Promising Practices

 Outreach Observations

 Action Step

 Gaps Identified

 Resources

The minutes are actually meeting notes, seeking to capture important information rather than exact statements. Minutes are taken by a notetaker who does not participate in the meetings. They are distributed by mail or email to all those on the mailing list, not just the individuals who attended the meeting.

 *Jill Lee, Health Connections North Valley* - Jill mentioned she was having a problem with 3rd party billing; when she ran a MassHealth (Medicaid) eligibility check, some clients' records showed them as still being covered by another insurer, although the clients didn't think they were still covered. Jim Smith said he had run into the same problem and had had difficulty in removing the "orphan" 3rd party insurer from the client's MassHealth record.

 *Pam Victor, Division of Medical Assistance*, noted that MassHealth's auditors require the MassHealth Member to submit written verification of the end date of the Member's 3rd party insurance. There is no substitution for this documentation. (Teens frequently don't know that they are still covered by a parent's insurance and run into this problem.) Outreach workers can call Pam with emergency situations. The request to have the 3rd party taken off the Member's record takes time for the 3rd Party Liability Unit to process - how much time she wasn't sure. Call the 3rd Party Liability Unit at 1-888-628-7526 or 1-617-357-4027.

 *Margaret Ellison, Northeast Behavioral Health* - She has been seeing 3rd party problems as well; it helps to call the old "orphan" insurance company and give them the fax number of the MassHealth Enrollment Center (MEC) involved to help get the MEC the written verification of the end date of the Member's 3rd party coverage.

STATE AGENCY UPDATES

 **MA Division of Medical Assistance (DMA administers MassHealth (Medicaid))** - Norma Filipo Reviews of Members' eligibility are continuing; it is important to get good addresses where members can be reached by mail. She is working in the schools on the Covering Kids initiative. For Public Health Week they recently invited school nurses to judge posters that students had created on public health topics. The Springfield Department of Health used the posters at their Public Health Week kick-off event.

 Tom Wolff asked if any follow-up had happened on the problem mentioned in the Boston Health Access Meeting with MassHealth (Medicaid) Members being sent multiple Eligibility Review Forms (ERVs). The problem is that any change to a Member's information during a profile, including an address change, causes another ERV to be sent out. The DMA has a backlog of forms to process - they are working on the multiple ERV problem.

MA Department of Public Health (DPH provides funds for public health programs and services)-
Dana Allen

 DPH is working with Partners for A Healthier Community, Inc. in Westburgh. Since the DPH regional office in Centertown already has a Health Access Unit in place, they have put in a phone line with a Westburgh exchange number that gets transferred to the Centertown Unit staff. Four of the six staff members are from Westburgh so they have local community knowledge - people who call the local number don't know the call has left Westburgh.

The Department of Transitional Assistance is giving DPH money for the F.O.R. (Follow-up, Outreach, Referral) Families program to follow up on families coming off welfare. Many families assume that losing welfare also means losing Medicaid, Food Stamps, and other benefits that they are actually still eligible for. DPH has funds to do four home visits per year to these families. The program is meant to

 Promising Practices

 Outreach Observations

 Action Step

 Gaps Identified

 Resources

The minutes include symbols in the left-hand margin that indicate whether a particular item is a Promising Practice, Outreach Observation, Identified Gap, or a Resource. This labeling mechanism allows for easy access to information. (The particular symbols used by the Massachusetts HAN come from Microsoft Word 97.)

be preventive, so that health benefits are continued uninterrupted through the families' coming off welfare. Six months prior to a family's welfare termination date an electronic tickler file sends the family's data to the F.O.R. Families program.

HEALTH CARE FOR ALL – STATEWIDE: Ana Bodipo-Memba

1. **Medical Interpreter Bill** - passed the House and received unanimous approval from the State Senate. If the Governor signs the bill as expected it will become law, requiring hospital emergency rooms and acute psychiatric care centers to provide appropriate medical interpreters for non-English speaking patients and their families. Many thanks to all who have pushed for this bill's passage. The law, once signed, will go into effect July 1, 2001. The Babel III Coalition is working on getting different stakeholders together to plan where the funding is going to come from.
2. The State Senate wound up its side of the budget debate on May 22nd. Thanks to the many folks who called their legislators, Health Advocates succeeded in getting 90% of its "wish list" included in the Senate language; three Senators and three Representatives will now go into conference to work out differences between the House and Senate versions, and come up with a "conference" budget to go to Gov. Cellucci. Ana requested participants to please call your Senator and Representative to let them know you support:
 - the House appropriation for MassHealth Dental reimbursement AND the Senate appropriation for increased community dental programs (Line items 4510-0110 & 4512-0500)
 - the Senate appropriations for CMSP, children's school-based outreach, and prescription drug coverage for children in CHIP plans (4590-0906, outside section 265, and 4000-1500 respectively)
 - Senate appropriation for community outreach minigrants (4000-0310)
 - Both the House and the Senate create a new prescription assistance program for seniors and people with disabilities. Please support the Senate's inclusion of people with disabilities enrolled in the current catastrophic plan as of 12/31/00 and two-tiered co-pay system for all low income participants.

Then Ana and Tom Wolff did a little skit with Ana playing the constituent and Tom playing the legislative aide who answers the phone. Ana explained her opinion on mini-grants to the "aide" using a previously prepared worksheet as a guide. The skit was meant to relieve people's anxiety about being put on the spot when contacting legislators. People felt the skit helped to demystify the process of doing advocacy. Legislators have 1400 or so bills put before them each session, and they appreciate having constituents tell them which bills require their attention. Every constituent's opinion matters to legislators and their staffs; they don't require you to know all the details of a bill, although knowing the line item number is very helpful to them.

Meeting adjourned promptly at noon.

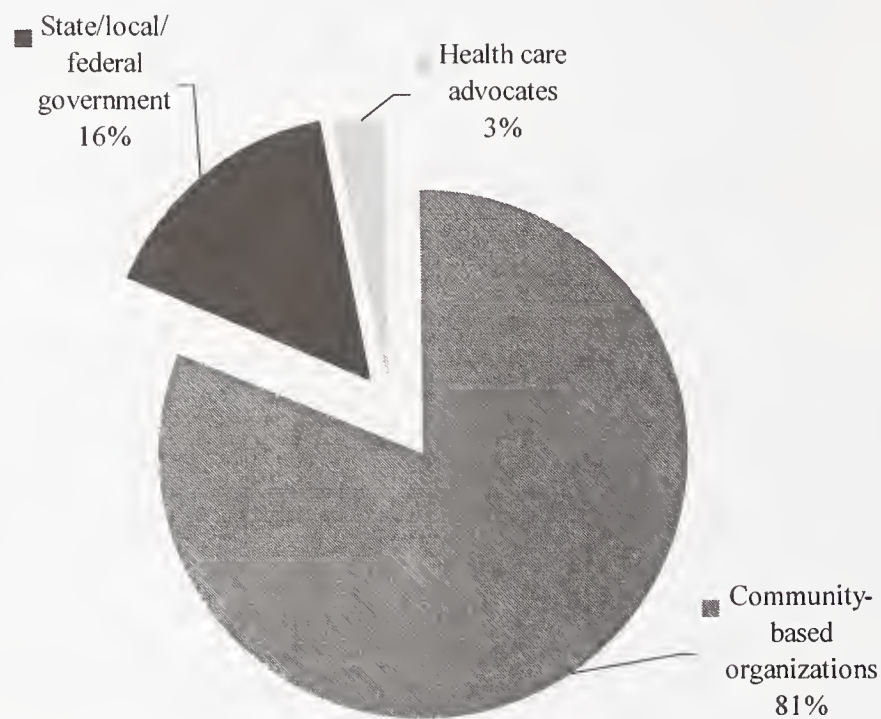
NEXT MEETING: JULY 7TH, 2000, 10:00 - 12 P.M. AT THE PUBLIC LIBRARY, ANYTOWN

 Promising Practices
  Outreach Observations
  Action Step
  Gaps Identified
  Resources

The minutes and agenda state the time and location of the next Health Access Networks meeting.

Who Attends Health Access Networks Meetings?

- Outreach workers
- Social service workers concerned with specific populations (including seniors, disabled, children, immigrants)
- Hospitals and Community Health Centers
- Representatives from state agencies
- Health care advocates



Average participation: 30-40 people (maximum of 50)

As this graph indicates, there is strong representation from all the stakeholders. The 81% of community groups includes community-based organizations, community health center staff and hospital staff.

By the Numbers

Participation Levels for the Health Access Networks (as of September 2000)

Number of people who have attended at least one meeting:

Since inception (March 1998): 1,039

Active in the last 12 months: 554

Number of organizations represented:

Since inception (March 1998): 464

Active in the last 12 months: 258

Communities represented:

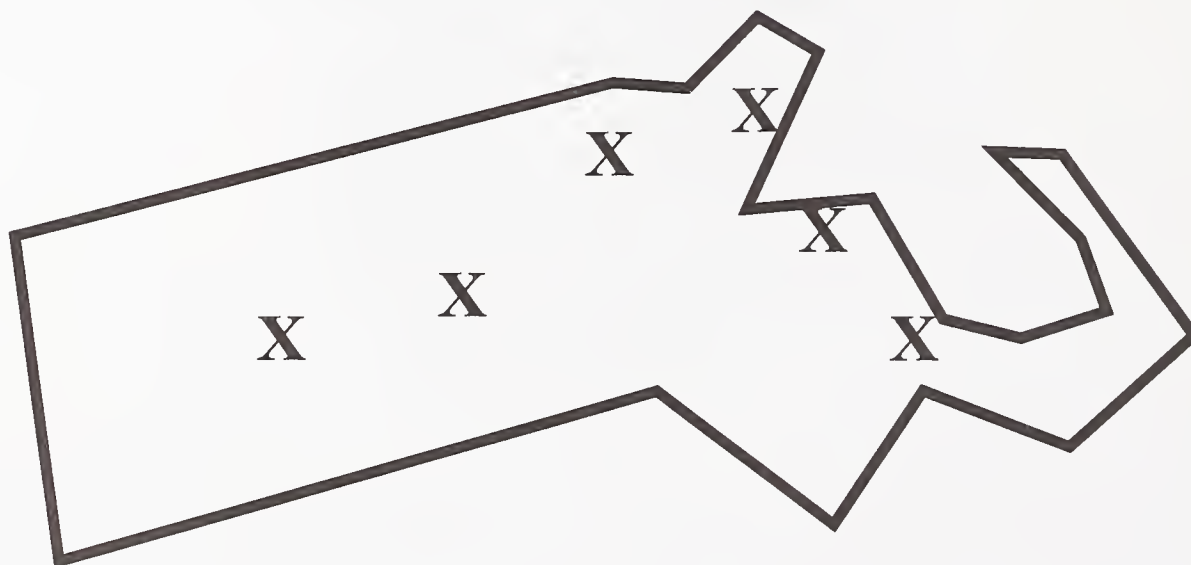
135 towns and neighborhoods

*38% of communities in the State**

**This figure is calculated based on the the mailing addresses of organizations whose representatives attend HAN meetings. This number could actually be higher, if we were to take into account that one organization may serve several communities.*

At a Glance

- Begun in March 1998
- 6 regional meetings each month
 - * Greater Boston
 - * Western Massachusetts
 - * Central Massachusetts
 - * Northeastern Massachusetts
 - * Southeastern Massachusetts
 - * North Shore
- Funded by state Medicaid agency via University of Massachusetts Medical School



The Health Access Network meetings are regionally-based so that outreach workers can attend meetings more easily and discussions can address more local needs or issues.

CHAPTER 8



How Do I Start a Health Access Network?

The power of the Health Access Networks program is that it can be adapted to any state or region in the United States. While the specific structure may not be appropriate for some locales, the program's functions and specific tools can definitely be replicated. Successful replication requires both the requisite conditions and thoughtful implementation.

This chapter will focus on the nuts and bolts of what is needed to develop a Health Access Networks-like program. Included are examples of materials developed to support implementation of the program.

This chapter includes:

Start Your Own Health Access Network

Sample Materials:

HAN Meeting Calendar

HAN Mission and Goals

Guidelines for Presenting

HAN Meeting Sign-In Sheet

Replication/Adaptation Checklist

HAN Checklist for Success

Start Your Own Health Access Network

Starting an effort like the Health Access Networks will make outreach, enrollment and post-enrollment more effective in your state. While some ingredients will vary according to what resources are available in your area, some elements cannot be easily substituted. We call these elements "prerequisites for success."

Prerequisites for Success

Recognition from legislators and policymakers, including the state Medicaid agency, that community-based outreach is essential

While state agencies have the goal of increasing enrollments in health insurance programs, communities have the connections and strategies to make outreach work. With the national goal of increasing enrollments established, state policy-makers are increasingly receptive to supporting community-based outreach.

Funding for community-based outreach

From the start of CHIP, community groups advocated for funding to do outreach to augment the state Medicaid agency's single focus on an extensive statewide media campaign. Once community-based outreach was established as the key to making CHIP work, the appropriate state agencies identified funds. The process for getting funding out to communities will vary from state to state. In Massachusetts, the Medicaid agency put out a call for proposals, communities completed the application, and successful applicants were awarded mini-grants of \$10-\$20,000. Examples of these grantees are: multi-service agencies, organizations serving immigrants or linguistically diverse populations, community health centers, housing groups, hospital community initiatives, women's shelters, and information and referral agencies. Clearly, outreach funds need to go to communities that are geographically and culturally diverse.

A statewide consumer advocacy voice

Health Care For All, a statewide consumer-advocacy organization, provides this voice at HAN meetings in Massachusetts. Identifying the advocates in your locale may require some creativity if you do not have a statewide health care advocacy group. If local or regional advocacy groups are your best bet, the advocates you partner with should be able to keep a statewide perspective on health access issues. With their expertise, the advocates can give participants avenues for policy change on current issues such as health access for immigrants, or a lack of dental providers.

Facilitators who can play a neutral convening role

In Massachusetts and many other states, Area Health Education Centers (AHECs) are in the unique position of doing statewide work and having a neutral role. The specific organization taking on this role may vary. Ideally, the convener(s) should be housed by an organization that has a statewide perspective and a neutral outlook.

Tips for Start-Up

Starting any new venture takes thoughtful planning, attention to detail, extensive communication among all the players, and finally, the courage to jump right in.

Bring the Players Together

Participants of Health Access Networks (HAN) meetings—communities, state agencies and consumer advocates—bring different perspectives into the room. Together these voices produce a lively and rich discussion, and ultimately make outreach and enrollment efforts more effective. Identifying those who will represent these differing viewpoints before you have your first HAN meeting is critical.

Who will represent the communities?

Inviting both supervisors and outreach workers allows community groups to decide who will attend from their program. Often a mix of both supervisors and outreach workers attend the meetings, finding that the exchange is valuable to each of them.

Who will represent the state agencies?

Who within the Medicaid agency or other state agencies will serve as liaisons to the community? Medicaid agencies often have regional or local offices; which staff from these will attend the health access meeting? Site supervisors can be invaluable liaisons on policy questions, while customer service representatives may want to come along to give detailed information on how the application process works. Statewide managers may also want to come from time to time to gain a better understanding of what is happening at the community level. Identifying a consistent representative from each state agency who will attend meetings allows solid relationships between communities and state agencies to flourish over time.

Which advocates will attend?

As mentioned earlier, a statewide consumer advocacy organization that works on issues of health care provides the best fit. Regardless of the organization or

the individuals you choose to represent the advocacy voice, identifying a consistent representative from the advocacy world gives the participants a “go to” resource person on policy change.

What other individuals or agencies with an interest in health access could you invite?

The broader the participation, the more effective your efforts will be. These other participants will vary from state to state.

Who will convene the meetings?

Running several regional meetings on a regular basis is time-consuming and labor-intensive. Funding needs to be identified for an organization to take on the overall convening and coordination role. With funding, this organization can: 1) take on the logistical coordination of the meetings; 2) ideally hire a program coordinator; and 3) hire lots and lots of administrative support! In addition, the meetings need to be run by trained facilitators who have an understanding of health access issues and experience in running large and complicated meetings. Trained, neutral facilitators create a safe space within the meetings for participants to come together and problem-solve their mutual concern: getting individuals and families the health care they need.

Plan the Meetings

Once a community has received funding for outreach, state agencies have identified who will serve as liaisons, advocates are chosen, and the neutral convener is decided upon, then it's time to plan and hold the first meeting(s). Before you step into your first HAN meeting, some key decisions still need to be made:

Decide how often to meet and set a regular meeting time.

Participants need to be able to rely on a set schedule: the third Thursday or first Tuesday of every month, for example. How often you meet may depend on funding, resources, or the coordination mechanisms already in place for health access in your state.

Define the meetings regionally.

Choose a town or city that people can realistically travel to on a regular basis. Outreach workers have demanding jobs and part-time schedules. In order to pull people together, the meeting needs to be a manageable car, train, or bus ride away.

Find and reserve a pleasant meeting space that is neutral.

The work of outreach and enrollment is in everybody's interest. Reflect this by meeting out in the community, not at a state agency. Find a space that is pleas-

ant and welcoming, preferably with natural light. Ensure that the space is accessible for those with disabilities, reachable by public transportation if you're in an urban area, and centrally located in the region that the meeting serves. Examples of meeting spaces that are neutral and often free include: libraries, housing projects, and donated space at businesses or universities.

Plan a clear agenda.

The agenda should reflect the needs and concerns of the communities, state agencies, and advocates. Be sure to create time in the agenda for everyone to participate fully in the meeting. We are often told that the HAN meeting is one of the most productive meetings people attend all month. This is due in part to the fact that the meetings have clear (often ambitious) goals, including updates from communities, state agencies, and advocates, as well as time for the exchange of ideas among participants. Time is set aside to identify and problem-solve current issues (such as lack of dental providers, mental health access, or benefits for immigrants).

Identify a note-taker for the meeting.

Capturing the exchange in the meeting is valuable not only for the participants who were there, but also for those unable to attend. The notes are a written vehicle to document gaps and issues, share best practices and identify valuable resources. In addition, we've found that policymakers who rarely attend, but want to track the issues, read the meeting notes religiously.

Notetakers may either be individuals hired to take the minutes, as we have done in Massachusetts, or a regular meeting participant. It is important to remember that notetakers do not participate in the meeting for which they take minutes, as they will need to focus on recording what is happening.

Convene the Meetings

We've learned that "the devil is in the details" Putting the nitty-gritty into place makes or breaks the effectiveness of the meeting:

Send out agendas, directions, and minutes from the last meeting ahead of time.

People need a trigger that the next meeting is coming up, as well as information about the agenda, so they can prepare. Bundling agendas and minutes to be mailed out together works well.

Provide food and drink for participants.

Since this is a regional meeting, people may have traveled a fair way in order to attend. Refreshments are a sign that you value those in the room and the effort

they made to get there. In addition, talking over a cup of coffee before and after the meeting helps build relationships. These relationships are the glue that makes outreach work.

Start and end the meeting on time.

This is another demonstration to participants that you value their time and efforts. Make it known that it is an important issue, and ask that the group work together to start and end on schedule.

Anchor the meeting with its mission and goals.

The goals of the Health Access Networks are printed on the back of each meeting agenda to remind seasoned participants and orient new ones to our common concern: creating health access for all.

Provide meeting packets that include current information and materials.

Encourage participants to contribute to the packet with effective outreach materials developed by organizations, local news articles, written policy changes from state agencies, or announcements about events. Highlight these materials in the meeting to bring the information alive and make it a vehicle for communication among participants.

Meet in a circle.

This models and creates an interactive meeting where everyone is the same distance from the center.

Make time in the meeting to hear from everyone.

This includes communities, state agencies, advocates, and any other participants (such as representatives from health care vendors or city public health commissions).

Pass around a sign-in sheet.

This allows you to add new participants to your mailing list, update information on current participants, and create a list of attendees for each meeting's notes.

Encourage people to stay afterward to network.

Building trusting relationships is the foundation of any effective outreach effort. Participants often stay to exchange business cards, discuss ideas for collaboration, or simply share photos of new grandchildren.

Keep the Meetings Going

Develop a well-functioning database for on-going communications with the participants.

A good database will help you to keep up-to-date contact information for participants, track participation at meetings, create directories of regional participants, and create labels for mailing out minutes and agendas.

Develop materials on demand.

Participants have told us what they need to do their jobs—a statewide who-to-call directory, for example—and we have developed and disseminated this resource: *The Health Access Directory: Statewide & Local Contact Information*. (For a list of other health access resources developed by AHEC/Community Partners, see “Resources” at the end of the book.)

Continue to encourage broader participation in the meeting.

Make this an open meeting that anyone can attend. Ask participants to invite friends and colleagues interested in issues of health access. The broader the participation, the more effective your efforts will be.

Ensure that conveners are available to participants between meetings.

It is helpful to have conveners available by phone and/or email for questions and follow-up on issues that have emerged during meetings.

Behind the Scenes

A lot goes on behind the scenes to make each round of HAN meetings productive and positive.

Convene the conveners.

The statewide nature of this work requires significant travel on the part of conveners, so chances are you'll identify more than one person to facilitate the meetings. Coordination among the conveners then becomes critical to maintaining the focus, intent, and quality of the meetings. Conveners need to come together between meetings to exchange ideas and strategies, as well as plan the next round. It is helpful to identify a project coordinator (or a lead convener) who can serve as the hub for information flow between the facilitators. In larger states, conveners can meet by conference call.

Use convener meetings to plan upcoming HAN meetings.

Each HAN meeting is an opportunity for productive exchange among participants, creating new linkages, problem-solving mutual concerns, and identifying best practices and resources. Planning the overall flow of the meeting, fine-

tuning the agenda, finalizing presenters, and inviting new participants are important steps to take before each meeting.

Use convener meetings to identify and address themes.

Themes that emerged in the last round of meetings—how a new CHIP program is being received by non-English speakers, for example—can present agenda items for the next meeting. Is there a presenter who can be invited to clarify a policy, teach about how different cultures approach health care, or tell the story of an innovative outreach strategy to the Latino community?

Evaluate Your Efforts

Evaluating the outcomes of a statewide health access network is important. This will help ensure that program goals are met, document any unexpected benefits from the meetings, and gather information regarding areas for improvement. This information can help you retain your funding, finetune your program goals, and disseminate (and celebrate!) meaningful outcomes from your work.

Each year AHEC/Community Partners has contracted with an independent evaluator, LinkAges Research Group, Inc., to evaluate the Health Access Networks by conducting participant surveys and key informant interviews. (See Chapter 8, *Do the Health Access Networks Work?*, for more information.)

Feedback Meetings with State Agencies

State agencies are eager to learn what is happening in communities in terms of outreach and enrollment, as well as issues of health care access generally. The conveners gather successes and challenges from the field and bring them to high-level managers at state agencies in quarterly feedback meetings. This feedback loop between state agencies and communities has become a critical facet of our health access work together.

Above and Beyond

Consider pursuing funding to bring together participants outside the regular meetings. For example, AHEC/Community Partners has coordinated:

Special trainings

Regional gatherings like the Health Access Networks convene outreach workers from many different communities. Trainings held before or after regular HAN meetings have become a golden opportunity to get specific information to community groups about new health insurance programs, cultural competency, and other timely topics. Providing lunch for the outreach workers allows them to “make a day of it.”

Focus groups and issue-oriented forums

Some issues need deeper discussion and problem-solving than is possible within a meeting's limited time. Convening focus groups and issue-oriented forums on gaps in access to dental providers, mental health coverage, the sustainability of the outreach worker role, and future visions for the health care system, for example, allow participants to take issues further. In addition, these forums can include decision-makers who may not regularly attend HAN meetings—such as federal and state agency representatives or state legislators—creating a breadth of experience in the room that leads to deeper problem-solving.

Community Health Outreach Worker (CHW) support lunches

Community health outreach workers have demanding jobs and need a place to share their experiences with their peers. We've organized CHW support lunches to give these incredible outreach workers a place to share their frontline stories—without their supervisors in the room.

Statewide conferences

Creating health access is a widespread movement. A statewide conference brings people together to celebrate their successes, share best practices, clarify ongoing challenges, and envision the future.

Obstacles

The best work we do together can often be the most challenging. You may encounter some obstacles:

*Lack of funding for community groups and / or the convening organization**Not getting all the right people in the room*

If state agency representatives or community outreach workers can't get supervisory approval to attend meetings, or if there isn't a reliable, skilled advocacy voice in the room, the meetings won't produce positive outcomes.

Lack of trust between the meeting participants

In the early stages of building a statewide network, it can seem like everyone is vying for the same "customers." Local state agency representatives may feel their jobs are being taken over by community-based outreach workers, while outreach workers new to this work may wonder how to work alongside state agency folks who have been in this "business" for many years.

Trust and understanding between outreach workers of different backgrounds

Outreach workers come from many different settings (rural versus urban) and different ethnic groups, which constitute different realities.

Getting stuck in old dynamics.

A HAN meeting may be the first time people from these different perspectives have sat in the same room together to work toward a common goal. Old dichotomous patterns can emerge, such as advocates versus state agencies, or funders versus fundees. Hopefully, the meetings will become a place where people can learn new ways of partnering with each other.

Getting beyond the need to put one's best foot forward.

The goal of the meetings is to learn what works and what doesn't work when doing outreach and enrollment. Some of the best lessons come from what didn't work—a stunted effort or failed campaign. If participants don't feel safe in sharing the less glamorous aspects of their work, the dialogue only goes so far.

The last thing anyone needs is “just another meeting.” What makes HAN meetings different is that they are productive, informative, and relevant to people's work. They are productive because the issues that are identified are acted upon by those in the room. Participants call decision-makers (supervisors, agency heads, legislators); state agency representatives bump up gaps in the system to high-level managers; advocates create campaigns to solve ongoing problems (such as the need for coverage of the working uninsured); and organizations plan collaborative and innovative efforts with each other. Everyone contributes to positive change. We've seen great obstacles surmounted with time and effort.

One HAN participant whose views changed said, “It's good for us as state people to see and hear directly what's going on from outreach workers...It's good for both sides to see the other's perspective—though I don't think it's ‘sides’ anymore. We both see we have a common goal and we're now working cooperatively.”



HEALTH ACCESS NETWORKS

CALENDAR 2000-2001

*Locations subject to occasional changes.
Call AHEC/Community Partners for up-to-date
information on your region's meeting.*

WESTERN (1st Friday of every month)

Jones Library – Amherst

10 a.m. – 12 Noon

Convener: Tom Wolff

July 7, Sept. 8*, Oct. 6, Nov. 3, Jan. 5, Feb. 2,
March 2, April 6, May 4, June 1

SOUTHEASTERN (3rd Wednesday)

Middleboro Library – Middleboro

1:00 – 3:00 p.m.

Convener: Phil Salzman

July 19, Sept. 20, Oct. 18, Nov. 15, Jan. 17,
Feb. 14*, March 21, April 11*, May 16,
June 20

NORTHEASTERN (3rd Thursday)

Mercier Community Center - Lowell

1:00 – 3:00 p.m.

Convener: Phil Salzman

July 20, Sept. 21, Oct. 19, Nov. 16, Jan. 18,
Feb. 15, March 15, April 12*, May 24*,
June 21

NORTH SHORE (4th Tuesday)

Beverly Hospital – Beverly

1:00 – 3:00 p.m.

Convener: Phil Salzman

July 25, Sept. 26, Oct. 24, Nov. 28, Jan. 23,
Feb. 27, March 27, April 24, May 22, June 26

GREATER BOSTON (4th Wednesday)

Northeastern University - Boston

1:00 – 3:00 p.m.

Conveners: Michael DeChiara & Diane
Johnson

July 26, Sept. 27, Oct. 25, Nov. 20*, Jan. 24,
Feb. 28, March 28, April 25, May 23, June 27

CENTRAL (4th Friday)

Tower Hill Botanic Garden – Boylston

10 a.m. – 12 Noon

Convener: Ellen Unruh

July 28, Sept. 22, Oct. 20*, Nov. 17*, Jan. 26,
Feb. 23, March 23, April 27, May 25, June 22

*Meetings that vary from the regular schedule
due to holidays or other conflicts

SAVE THE DATE: MAY 17, 2001
STATEWIDE HEALTH ACCESS CONFERENCE

HEALTH ACCESS NETWORKS is a program of AHEC/Community Partners
24 S. Prospect Street Amherst, MA 01002 413-253-4283 www.ahecpartners.org

HAN meetings are scheduled at regular times on regular days of the month. This, in addition to publishing and distributing the dates well in advance, helps make the meetings a part of participants' busy schedules. This also makes the meetings accessible to newcomers.



HAN Mission and Goals

The Health Access Networks (HAN) is designed to bring together individuals, organizations and systems who are committed to getting the uninsured and underinsured members of our communities linked to health care services.

People who come to HAN meetings make up the three legs of our collective footstool: the first leg is the community-based organizations that do grassroots outreach and enrollment; another leg is the state agencies which run health care programs (primarily the Division of Medical Assistance and Department of Public Health) ; and the third leg is advocates, represented by Health Care for All.

The role of AHEC/Community Partners is to facilitate the meetings and provide administrative support for the network. Our objective is to have people share information and experiences, build relationships with each other, and become resources to each other in order to achieve our mutual goal: increasing the number of people that receive the health care services they need.

Group Agreements Identified Across Health Access Network (HAN) Regions

- Listen respectfully. Talk one at a time.
- We all participate/talk. Everyone is heard.
- Have a clear agenda
- Take and mail minutes to everyone
- Act as a reliable resource to others – bring printed information to share
- Follow-up from meeting to meeting is always provided
- Try to start and end on time
- When giving criticism, be constructive and also note positives
- Limit comment – respect that there is a limited amount of time for everyone to make comments
- Welcome new people – this is not a closed group
- Explain acronyms, e.g. “ERV” and “CHIP” so that everyone will know what is being talked about
- Appreciate our successes

The mission and goals of the Health Access Networks are printed on the back of every agenda. Also included are the Group Agreements, that is, the operating rules identified by meeting participants. Both of these items provide an immediate orientation to meeting newcomers.

The success of the meetings is based upon fostering a safe space for all participants, and understanding the commitment of all participants to issues of health access. The goals and mission, along with active modeling by the convener and long-time participants, allow the values of the meeting to be transferred to new participants.

Guidelines For Presenting at a Health Access Networks Meeting

Thank you for taking the time to present at an upcoming Health Access Network (HAN) meeting. Below is some information, which you should review. HAN meetings strive to be resources for the participants – the stronger and more prepared your presentation, the more people will get out of it.

The Meeting

Who Participates:

HAN meetings include three groups of participants: community based outreach workers, state agency workers, and health care advocates.

Goals of the Meetings:

1. Disseminate information (timely and relevant to those in the room)
2. Share best practices (regarding outreach and health access generally)
3. Develop relationships (for future resources, information and support)

Meeting format:

Each meeting has three standard parts. Each provides “air-time” to the 3 types of participants in the meeting.

- Communities: updates from local community-based organizations only (20-40 minutes)
- Advocates/Consumer voice: Health Care For All update on legislative, regulatory and market information (30-40 minutes)
- State agencies impacting health care: updates including, but not limited to: Division of Medical Assistance, Dept of Public Health, Division of Health Care Finance and Policy (20-30 minutes)

What You Can Do:

As an invited presenter, you bring important information to the HAN meetings. We greatly appreciate the time and thought you will put into your presentation and the materials you will provide to the participants. You can help to ensure that accurate and informative resources on health access continue to flow.

Presentation

We ask that your remarks be focused and to the point. Please keep in mind that we try to accomplish many tasks at our monthly HAN meetings. First and foremost, this is a time for community members to highlight their work and learn about what resources are available for them in support of their work. Any successful presentation will also provide adequate time for questions and follow-up discussion.

HAN meetings are unlike most meetings where presentations are made. There is a premium put on sharing information that is helpful to those in the field. For example, presenters are encouraged to bring business cards or give their phone number, have handouts and leave ample time for questions. Presenters discover they both provide and receive information in these meetings.

Handouts

Short, concise handouts should accompany information discussed in HAN presentations. People need to be able to take away materials for their own use, later review or to share with others. User-friendly descriptions that clearly explain or highlight what is being presented are also strongly encouraged. **All handouts should include pertinent telephone and fax numbers, web addresses, contact names and towns/regions served.** (Please call 413-253-4283 for recommended number of copies needed.)

Important: If you do not plan to bring handouts for distribution to the group, please bring at least one copy, or hand write the information for our note-taker to ensure that she/he has accurate contact information. We encourage you to fax handouts and information ahead of meeting time to 413-253-7131.

The Convener: "On Topic and On Time"

The convener is your on-site "go-to" person. He/she facilitates the discussion and manages time. Please respect that the convener may need to ask you some pointed questions to ensure clarity in your presentation and may have to ask you to cut your presentation short if you are going over your allotted time. There is time after the meeting for participants to ask additional questions. Please feel free to use that time.

The Minutes:

Every HAN meeting has meeting notes (the minutes). Key discussion points, resources and issues are gathered by the note-taker. These minutes are distributed to all meeting participants, as well as other stakeholders who are unable to attend the meetings.

Logistics:

If you have additional questions please feel free to contact Michael DeChiara or Ellen Unruh at **AHEC/Community Partners** at (413) 253-4283 or mdechiara@ahecpartners.org and eunruh@ahecpartners.org.

If you need directions to a meeting, to confirm a date and time, or audiovisual aids please contact Elissa Small at **AHEC/Community Partners** at 413-253-4283 or esmall@ahecpartners.org.

We look forward to your presentation at an upcoming HAN meeting! Feel free to be creative!

Guest presenters need to get oriented to the norm of the group—that this is a safe space for asking questions, that respect for all meeting participants is paramount, and that it is important to provide useful information that can be applied directly to the work of those in the room. Each presenter is contacted prior to the meeting by someone associated with the HAN program to establish clear expectations for success.

Health Access Network Meeting
Sign In Sheet _____

HAN Region Southwest

Meeting Date: 1 / 1 / 2006
Convener: John Doe

If you have signed in before – Please include only your name and organization unless your information has changed, e.g. you've moved office or if you now have e-mail

1	NAME	David Goodman		PHONE W/ AREA CODE	1893 1547-6375	YOUR POSITION	Activist
	ORGANIZATION	Senior Action Council		FAX W/ AREA CODE	1893 1577-6382		
	ADDRESS	15 Elm St, Anytown		ZIP CODE	08972	EMAIL	
2	NAME	JIM SMITH		PHONE W/ AREA CODE	()	YOUR POSITION	
	ORGANIZATION	ABC HEALTH CARE		FAX W/ AREA CODE	()		
	ADDRESS			ZIP CODE		EMAIL	JSMITH@HERA.COM
3	NAME	Alicia Martinez		PHONE W/ AREA CODE	()	YOUR POSITION	
	ORGANIZATION	Salud Latina, Inc.		FAX W/ AREA CODE	()		
	ADDRESS			ZIP CODE		EMAIL	
4	NAME	Jill Lee		PHONE W/ AREA CODE	()	YOUR POSITION	
	ORGANIZATION	Health Connection / N. Valley		FAX W/ AREA CODE	()		
	ADDRESS			ZIP CODE		EMAIL	
5	NAME	JUAN RAMIREZ		PHONE W/ AREA CODE	1893 1561-0357	YOUR POSITION	OUTREACH WORKER
	ORGANIZATION	ANYTOWN HEALTH DEPT.		FAX W/ AREA CODE	1893 1561-0332		
	ADDRESS	23 MAIN ST, ANYTOWN		ZIP CODE	08972	EMAIL	

Page _____ of _____

Keeping people in the information loop is crucial to the success of the Health Access Networks. Each person who attends a meeting will receive that meeting's minutes and agendas for subsequent meetings. Many people are unable to come to every meeting, but actively follow the minutes. This is particularly true for policy-makers. In addition, mailings, emails, and faxes are occasionally sent out to alert participants to training and funding opportunities. An active and up-to-date database is essential to the success of this program.

***Note:** Blank forms are available for reproduction in the "Steal This Section" at the end of this book.

Replication and/or Adaptation: Checklist for Starting a Health Access Network

- ☐ Confirm the readiness of your state/region
What is the status of your state and communities regarding initiatives to support community-based outreach and increase enrollment in publicly-funded health insurance programs?

- ☐ Identify the needs to be met
For example, are there organizations working on expanding health access, but no mechanism for coordination? Or is there a need for more accurate information to be distributed so organizations can be more effective?

- ☐ Clarify what functions can be provided
Design your states' system based on your specific needs and the capacity of the coordinating organization.

Examples:
 - Information exchange
 - Sharing best practices
 - Creating linkages between communities and state agencies
 - Identifying and problem-solving current issues (e.g., lack of dental providers, barriers for immigrants)

Health Access Networks Checklist for Success

- ☐ *Ensure a neutral convening role to promote communication*
- ☐ *Work in collaboration with other key players (hospital associations, community health centers, advocacy groups)*
- ☐ *Provide opportunities for varied voices*
- ☐ *Create a mechanism for regular feedback to the state agencies*
- ☐ *Follow-up with participants*
- ☐ *Build the capacity to develop requested materials*
- ☐ *Evaluate your efforts*

CHAPTER 9



Do the Health Access Networks Work?

The Health Access Networks have been a success in Massachusetts, credited with playing a significant role in making outreach efforts effective.

This chapter will focus on evaluation of the program and what HAN has achieved.

This chapter includes:

Do the Health Access Networks Work?

Summary of Findings: Key Informant Survey

Summary of Findings: HAN Participant Survey

Testimonials to Effectiveness of the Health Access Networks

HAN Produces Tangible Results

Letter of Support from Medicaid

Do the Health Access Networks Work?

The Health Access Networks have produced tangible results for everyone involved in trying to expand health access for state residents. HAN has expanded the ability of state agencies to engage consumers through direct access to community groups, which is particularly useful when promoting new programs or policy changes. HAN provides communities with timely, accurate health care information, and direct access to state representatives for problem-solving. By bringing all the interested parties together to identify gaps and brainstorm solutions, HAN improves the likelihood of enrollment into publicly-funded programs for those trying to access health care. Ultimately, as a result of this increased coordination and information sharing, consumers—people in our communities—have better access to health care coverage for themselves and their families.

Formal and Informal Evaluation

The success of the Health Access Networks has been documented both informally and formally. Informally, meeting conveners solicit feedback from the participants of each meeting on a regular basis by asking them, “What’s working in this meeting? What could be changed?” Conveners list the participants’ feedback on a flipchart for everyone to consider. Positive feedback affirms the accomplishments of the network: “People are great resources to each other;” “Trust exists in the room.” Suggestions from participants create an opportunity to make improvements: “We’re missing the Southeast Asian organizations;” “What about trainings on special topics?”

Formal evaluation of the Health Access Networks has also been a core activity from the start. AHEC/Community Partners contracts with an independent evaluator, LinkAges Research Group, Inc., to evaluate the Health Access Networks on a yearly basis. (See Chapter 11, *Outreach and Health Access Resources*, for more information)

Whether you subcontract with an evaluator or administer the evaluation yourself, the most potent results emerge when the process is kept simple:

- Spell out the goals of your program
- Formulate questions to discover whether your goals have been met
- Tabulate, summarize, and disseminate your findings to those interested in your program, including participants, funders, and other supporters
- Based on the evaluation results, fine-tune the program’s structure to better meet its goals the next year.

Once you have your evaluation findings, it is important to distribute them. The more people know about your program and what it achieves, the more they may want to participate in or support it.

Evaluation Example

Below is a simple example of the evaluation technique applied by the Health Access Networks. By working with a professional evaluator, the program was able to state what it wanted to learn from an evaluation, and then have that translated into appropriate and productive questions.

Program Goal: *Exchange information on changing health care programs and policies*

The 1998 Participant Survey Question asked: "How effective is the Health Access Network in achieving its goal of disseminating information?"

The Tabulated Results from the Question: 94% of surveyed participants said that HAN is effective/very effective in disseminating information

On the following pages, you will find excerpts from several HAN evaluations to give you a sense of the process we followed, as well as examples of the results.

Summary of Findings: Key Informant Survey

The HAN Evaluation Report, September 2000, consisted of key informant interviews with 36 HAN meeting participants who are outreach workers, program supervisors, and staff at the Division of Medical Assistance and Department of Public Health. The findings from the interviews affirm that the HAN continues to achieve its three original goals:

- Exchange information about changes in health care programs and policies,
- Create linkages among and between community-based organizations and state agencies, and
- Share promising outreach practices that engage people in need of health care.

In addition, the findings indicate that HAN is making a notable contribution to identifying gaps and barriers to health care access, and facilitating a response to these at both the legislative and state agency level. These emerging capacities were first identified in the 1999 evaluation of HAN.

Besides answering a series of open-ended questions, key informants were asked to respond to a set of four statements about HAN, and there was almost unanimous agreement with the contribution of HAN in these areas:

- *All agree* HAN has created a feedback loop between community-based organizations and state agencies regarding field-based issues.
- *All agree* HAN has helped identify gaps and barriers to serving the under and uninsured.
- *97 percent agree* HAN has contributed to increased enrollment of individuals and families in publicly funded health insurance such as MassHealth and CMSP.
- *97 percent say* HAN has raised awareness about the importance of outreach in getting people health care.

Key informants also provided constructive suggestions for ways that HAN could enhance achievement of its major goals and objectives including aspects of HAN meetings, HAN statewide coordination, and resources for outreach workers.

In this report, the positive influence of HAN is described by key informants at the personal/professional, and organizational levels, as well as in terms of impact on health care access as a whole.

Summary of Findings: HAN Participant Survey

The Health Access Networks (HAN) include five regional forums of exchange among community-based organizations, state agencies and health-care advocates. In October and November 1998, a survey was conducted and completed by 126 HAN participants. Four out of five respondents said that HAN is effective in helping them promote health access in their communities. In addition, here's how HAN is meeting its primary goals:

Goal 1: Exchange information about changes in health-care programs and policies

- 94% say HAN is “effective” in *disseminating information*

Goal 2: Share promising practices to engage people in need of health care

- 90% say HAN is an “effective” forum for *sharing best practices*

Goal 3: Serve as a link between communities and state agencies

- 90% find the *exchange with representatives from state agencies* to be “helpful” in enhancing their ability to do their work
- 85% say HAN is “effective” in *building relationships* among participants

Testimonials to the Effectiveness of the Health Access Networks*

Creating Linkages

"Connections began popping up for me that I hadn't expected. The...state and community networking was more than a geometric progression. It was a $1+1=3$...that was great."

"HAN has opened lines of communication between the state, community-based organizations and outreach workers that would not have been opened to this extent otherwise."

Exchanging Information

"HAN is an incredible forum for asking questions and getting answers, and to stay on top of what's new and changing. The information helps people be proactive rather than reactive."

"More than once I've encountered problems in my daily responsibilities, but with the knowledge gained from the [HAN meetings] I was able to address concerns as well as provide answers and referrals."

"HAN makes it easy for people like myself, outreach workers, to provide information to our clients."

Sharing Best Practices

"By supporting community outreach workers and giving them the opportunity to talk about what does and doesn't work, it's provided the opportunity to reach families that are hard to reach, people who sometimes fall through the cracks."

"HAN has played a very important role to help extend our services to people. We have improved our work and the number of people who get health care."

Feedback Mechanism

"It's a good place to discuss the real problems in health care access."

The people at the top don't know what it's like dealing with people at the street level, and hearing our perspective they get different points of view and they say, "I didn't know it was like that and how can we rectify the situation?"

*From *Key Informant and Participant Survey Reports, 1999 and 2000.*

Prepared for AHEC/Community Partners by Christine Clements Stein, LinkAges Research Group, Inc.

HAN Produces Tangible Results

...for State Agencies

- Direct access to community groups when promoting new programs or policy changes
- Access to feedback from the “field” about program design and implementation
- Sources of field-tested ideas for marketing
- Expanded ability to reach further into service areas
- Positive public relations about working with communities

...for Communities

- Program information is available on a timely and accurate basis
- Direct access to state agency representatives for problem-solving and information
- Training by state agencies for community groups is available regarding health programs
- Forum for highlighting health access barriers, administrative issues and service gaps
- Forum for brainstorming solutions
- Forum for gaining new skills or perspectives to enhance effectiveness of outreach work



ARGEO PAUL CELLUCCI
Governor

JANE SWIFT
Lieutenant Governor

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Division of Medical Assistance
600 Washington Street
Boston, Massachusetts 02111

WILLIAM D. O'LEARY
Secretary

MARK E. REYNOLDS
Acting Commissioner

May 24, 2000

Dear Participants of the Health Access Networks,

I would like to commend and thank you for your work providing outreach for MassHealth and the Children's Medical Security Plan in communities throughout the Commonwealth. Your commitment and expertise in knowing where to go and how to engage uninsured residents has played a valuable role in Massachusetts' ability to expand enrollment in these programs. According to the Kaiser Family Foundation, between June 1997 and June 1999, enrollment in Medicaid (MassHealth) in Massachusetts was up 32.4%—the highest of the 21 states surveyed. I am convinced that we could not have reached such levels without the support of the community-based organizations working in partnership with the Division of Medical Assistance and the Department of Public Health.

I would also like to encourage you to continue your active participation in the Health Access Networks. As Acting Commissioner of DMA, I have seen the importance of these meetings; their ability to bring together community outreach workers, state agency representatives and advocates — working towards a common goal. In addition, these meetings have been important to those of us who oversee MassHealth and CMSP; they have served as an effective forum for providing up-to-date information to you in the communities and to hear feedback about issues that you experience at the community level. The Health Access Networks have clearly helped your organizations and the Division to be more effective.

As I depart my position as Acting Commissioner, I am proud of what we have accomplished to expand health care access in Massachusetts. The past two years have been significant; I wish you all continued success in achieving more for those you serve.

Sincerely,

Mark E. Reynolds
Acting Commissioner
Division of Medical Assistance

The partnerships that are created through the Health Access Network are supported at both the community level and the policy-making level. The letter of support from the Acting Commissioner of Medicaid in Massachusetts clearly indicates that he is aware of the program and the community-based outreach efforts and understands the benefits that these initiatives provide in increasing enrollment.

Section IV

Next Steps in Health Access



CHAPTER 10



Moving Beyond Enrollment

It becomes apparent to anyone doing outreach that the work does not end with enrollment. Just as we learned that eligibility does not equal enrollment, so too, enrollment does not equal health care. The next challenge is to work in collaboration with communities to ensure that those with health insurance cards can access the health care services they need and deserve. This chapter will address the important issues beyond enrollment—getting and utilizing health care services.

This chapter includes an essay on the issue of post-enrollment, as well as a profile of a specific program which addresses this next step in the health access continuum.

This chapter includes:

A Card Is Not Health Care

Moving Beyond Enrollment
Program Profile

Observations

Distribution of Outreach
Worker Activities

Case Study of a Household
Working with an Outreach
Program (Part II)

Sample Forms for Moving
Beyond Enrollment Activities

A Card is Not Health Care

In 1997, the public policy challenge regarding health care access was to advance the understanding that “eligibility does not equal enrollment.” The state Children’s Health Insurance Program (CHIP) was adopted to act on this understanding and to enroll some of the 10 million uninsured children in the United States. The challenge for health access in the year 2000 is to understand that “enrollment does not equal health care.” A subsequent program initiative is necessary to help children and their families who have health insurance cards as a result of CHIP and Medicaid get real health care services. We need to extend the goal and move beyond enrollment.

Toward this end, AHEC/Community Partners, working in Massachusetts, has launched several programs that focus on *Moving Beyond Enrollment* activities. These programs are built on the foundation of innovative, community-based outreach programs and strategies for which Massachusetts has been recognized as a leader. The ultimate goal is to develop community-based systems that can respond to the health needs of people enrolled in CHIP or Medicaid by connecting them to providers or appropriate medical services.

Specifically, it is important to understand that receipt of a Medicaid or CHIP card is just the first step in the continuum that should end with the appropriate use of health and medical services. Along the road from enrollment to utilization, effective outreach programs must assist people with an array of often time-consuming post-enrollment issues. These include administrative problems (non-working cards, additional verifications, etc.); health plan and provider selection; health plan member education; education about how to use managed care; and making an initial visit to a provider.

These follow-up services are especially necessary for individuals and households who either have never had health insurance or have been without insurance for a long time. The goal of *Moving Beyond Enrollment* is to help people access appropriate services, understand the needs and benefits of prevention, and ultimately to improve their health.

AHEC/Community Partners began the following initiatives in the year 2000:

- A federally-funded rural health outreach program, *Moving Beyond Enrollment*, that builds upon successful community-based outreach programs and seeks to provide post-enrollment follow-up services. *Moving Beyond Enrollment* is intended to help individuals and households connect to the appropriate health care provider(s) and/or health and medical services. The program is funded for three years.

- A pilot mini-grant program funded through the University of Massachusetts Medical School to ten community-based outreach programs. This funding allowed these programs to expand services beyond outreach and enrollment and implement a variety of strategies that help connect individuals to appropriate providers or services.

As of May 2000, the Commonwealth of Massachusetts, through its innovative Health Care Access and Outreach Services mini-grant program, also began encouraging community-based outreach programs to provide post-enrollment follow-up and support services.

AHEC/Community Partners firmly believes that given the evolution of CHIP and the pressing need to improve the health of our children and families, *Moving Beyond Enrollment* needs to be embraced as the next step for health access public policy. The objective should be to utilize the effective partnerships developed through CHIP at the federal, state, and community levels to support those newly-insured people in receiving the actual health care they need and deserve.

Moving Beyond Enrollment

Program Profile

The *Moving Beyond Enrollment* program works with residents of rural Massachusetts communities who are enrolled in publicly-funded health insurance to get appropriate health care. The program builds upon the foundation of strong community-based outreach and enrollment programs to provide post-enrollment support services. The objective is to help residents connect with health care providers and medical services. *Moving Beyond Enrollment* works in partnership with communities—residents, organizations and human service providers—to expand health access for rural Massachusetts residents.

The program is based in three distinct rural regions of Massachusetts: the Lower/Outer Cape, the North Quabbin and the Southern Berkshires. These regions consist of communities which have been federally designated as “Medically Underserved Areas” and whose residents have been federally designated as “Medically Underserved Populations.” All three regions have thriving community-based outreach and enrollment programs that effectively serve the residents.

Moving Beyond Enrollment firmly believes that people have the right to appropriate, affordable and accessible health care.

Moving Beyond Enrollment Goals

The primary goal of the program is to establish functional relationships between people enrolled in publicly-funded health insurance programs and an appropriate primary care provider so that, once insured, people may receive appropriate health care services.

Moving Beyond Enrollment Objectives

The program has several objectives that address the needs associated with making connections between newly-insured people and medical providers and services. *Moving Beyond Enrollment* staff work with:

- **Individuals** to connect them to appropriate medical providers and services once insured;
- **Providers** to help facilitate the connection to new patients covered by publicly funded insurance;

- **Community systems** to help identify barriers and create solutions so people can get to the providers and receive their covered services; and
- **State systems** to identify barriers and create solutions to promote appropriate use of services and access to covered medical services.

Moving Beyond Enrollment Activities

Program staff:

- Track the actual enrollment process, making sure all prerequisites to care are in place (working card, documentation) so services can be utilized;
- Meet with clients once eligibility is determined to assist and educate them about the process for selecting an appropriate primary care provider, the importance of making an initial appointment (sick or well), and the system of managed care;
- Follow up to make sure initial visit takes place and address any barriers;
- Work with provider offices to assist with establishing and maintaining relationships with new publicly funded patients; and
- Work with state health care systems (primarily Medicaid) to identify system priorities and requirements, and identify opportunities for complementary activities

Observations

After one year of operation with the Moving Beyond Enrollment program, several findings have emerged.

Working with Government

In the early days of the program, conversations with the state Medicaid agency revealed areas of mutual interest. Specific concerns included:

- *Helping new enrollees to select a primary care physician*
- *Assisting providers with outreach to new patients*
- *Providing education about managed care and benefits, and encouraging preventive care*
- *Following up with patients approaching redetermination of eligibility*

Working with People in Communities

As outreach staff worked with families who had enrolled in a Medicaid plan, they gathered experience that supported some of their earlier expectations:

- *Most of the families selected their own primary care provider, but a portion had a provider selected by the Medicaid agency.*
- *Most of the individuals who had received some medical care since their enrollment had not received physicals, routine check-ups or well child visits.*
- *While services covered by Medicaid plans are explained in a member booklet, many families felt that they understood their plans much better when the explanations were amplified by an outreach worker.*
- *A number of families, confused by mailings they received during their annual eligibility review, turned to their outreach workers to get clarification and support during this process—an important step, since failure to respond can result in termination of eligibility.*

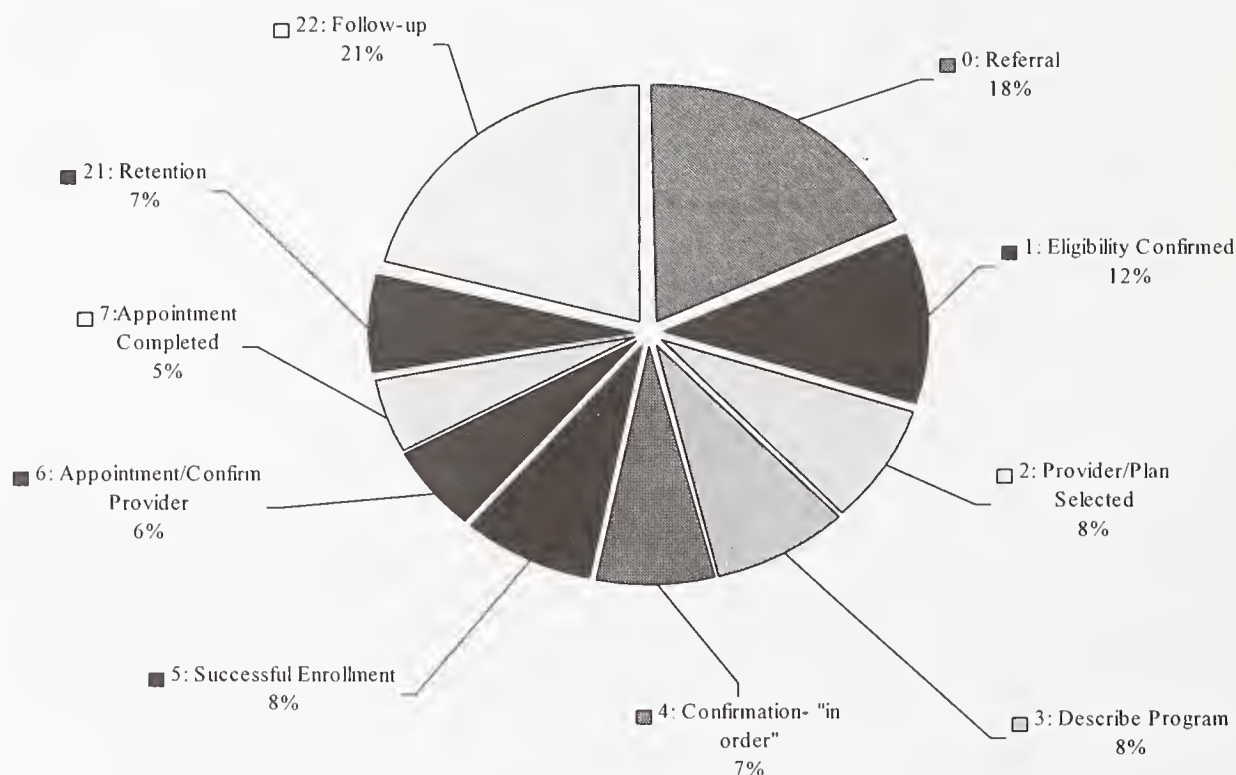
Once people have insurance coverage, issues such as the inability to get questions satisfactorily answered by customer service operations, incorrect billing, lack of transportation, or appropriate language interpretation can act as barriers to care. Moving Beyond Enrollment activities carried out in the context of the good relationships outreach workers establish with clients, providers, and state agencies can be instrumental in helping newly-insured individuals overcome these barriers, often preventing a problem before it arises.

Working with Providers

Large medical practices may have new patient outreach protocols and staff to carry them out; smaller rural practices often have no practical equivalent and must rely on the patients to come to them. In these areas, and others, outreach and follow-up provided by Moving Beyond Enrollment staff can facilitate the connection between new patient and provider.

Distribution of Outreach Worker Activities

Enrollment/Post-Enrollment Activities	
Referral Made	0
Eligibility Confirmed	1
Provider & Plan Selected	2
Describe Program; How to Use System; Why Prevention is Good	3
Confirmation- Everything in Order	4
Successfully Enrolled!	5
Initial Appt Made OR Confirm Existing Provider Relationship	6
Initial Visit Completed OR Appropriate Services Received	7
Post-Service Assessment Done	8
Related Activities	
Retention/Re-enrollment Activity	21
Follow-up Activity	22
Arrangements for Addt'l Medical/Related Services	23



The grid above outlines the various individual steps that must be taken with individuals to ensure that they successfully become enrolled, get health care, and retain their coverage. The pie-chart shows the breakdown of these activities over the course a month for an outreach worker.

Case Study of a Family Working with an Outreach Program (Part II)

Remember the Scofields? Back on page 44, Roger, Mattie, and their three children were introduced to an outreach program. They applied for Medicaid with the help of Joanne, an outreach worker. The three children received notices of eligibility for a comprehensive Medicaid medical plan, but the parents were denied.

When the family received notices of eligibility for the children in February, the outreach program did, too. At this point, Joanne called Mattie and invited her into the office to complete the process. Roger and Mattie had no experience with managed care; Mattie didn't realize that unless she chose a medical plan and primary care provider for her children, they would be assigned, which could result in inappropriate or inconvenient choices. Joanne explained how it all works, and that the family didn't need to wait until someone was sick to get medical care. Mattie made a phone call to MassHealth with her choice right from Joanne's office.

Three weeks later Joanne received a call from a local pediatrician's office she had worked with often. "Jeff Taylor is here for a check-up," Joanne was told. "His mother gave us a Medicaid card, but when we tried to put it through we learned that Jeff has a different insurance policy, one that our office no longer accepts. We thought you might be able to help." Joanne assured the office that it was a mistake, that Jeff should be covered by Medicaid, and that she could straighten it out. She invited Mattie to come to her office right away.

When Mattie arrived, they called Medicaid Customer Service. Joanne helped her get through the phone menus and explain the situation to a representative, who discovered that the old policy formerly carried by Jeff's father had not been cleared from the records.

Mattie was relieved that the error was discovered when Jeff was stable and not when he was in the middle of an asthma attack. Joanne helped her contact the former insurance company and get written verification that the policy was no longer in effect, satisfying the Medicaid central office requirement *BEFORE* Jeff found himself in urgent need of care. Joanne called at the end of the month to confirm that the change had been made and that Jeff's card had worked. Mattie was happy; regular use of an inhaler was helping Jeff spend more time in school.

Joanne was delighted that Mattie had acted on her suggestion to get preventive care for her children, and that Jeff was now in good medical hands. She was still concerned about Mattie's thyroid condition and Roger's back pain, however. Without insurance, they were hard put to take care of themselves. Joanne referred them to an open Center Care program at the local Community Health Center, which includes access to

Free Care at the local hospital. She also referred them to a special Medicaid program that offers coverage to qualified self-employed people. While that application was in process, she got Mattie connected with a state-sponsored thyroid clinic that was able to help her get testing not available through Center Care. Joanne helped Roger with his application for a local foundation's prescription drug program, which allowed him to get the medication he so badly needed to stay on the job.

Life seems to be improving for the Scofields. They stay in touch with Joanne—to the extent of coming by her office for more flyers to put in the school nurse's office and to give to their friends.

CONFIDENTIAL

Form 2.1

MOVING BEYOND ENROLLMENT
INDIVIDUAL/ HOUSEHOLD SERVICE HISTORY (office use)

Household ID# Z-4126 Individual ID# Name: Jeff Taylor
 Address: 122 State Rd. Town: Pleasantville Zip: 00000
 Phone: Alt. Phone:
 Has existing relationship with a provider: Yes No ✓ If yes, name:
 Existing Health Coverage Programs: Plan:

Health/Medical Continuum

MBE Step	Description	Date	Done	Comments
0	Referral Made	2/3/00	✓	
1	Eligibility Confirmed	2/14/00	✓	
2	Provider & Plan Selected	2/22/00	✓	
3	Describe Program; How to Use System; Why Prevention is Good	2/22/00	✓	
4	Confirmation- Everything in Order	3/28/00	✓	
5	Successfully Enrolled!	3/28/00	✓	
6	Initial Appt Made OR Confirm Existing Provider Relationship	3/14/00	✓	
7	Initial Visit Completed OR Appropriate Services Received			
8	Post-Service Assessment Done			

RELATED MBE ACTIVITIES

Code	Date	Comments	Code	Date	Comments
22	3/14	Dr. off called - Jeff's on old ins contacted Cust. Serv.			
22	3/16	Mattie in - wrote old ins. co.			
22	3/27	Rec'd copy of ins. co. letter to Medicaid			
22	3/28	Mattie in - verified change			

20- Arrangements for Add'l Medical/Related Services
 22- Follow-up Activity

21- Retention/Re-enrollment Activity
 23- Misc. Assistance/Activity

Client Related Information:

Provider Name: Dr. Brown Health Plan: PCC
 Other:
 Initial Appt Date: Time:
 Medical Needs: Asthma - needs inhaler

Status: (record on monthly service form)

Completed/No More Action Necessary (c) Retained/Re-enrolled (RT):
 Denied for Coverage (d): Date: Not Eligible for Anything (n):
 Terminated (t): Date:

The Individual/Household Service History Form used for the Moving Beyond Enrollment program differs noticeably from that used when performing simple outreach and enrollment. This form is designed to identify the range of distinct steps and activities necessary to move someone along the continuum from outreach referral to actual use of health care services.

***Note:** Blank forms are available for reproduction in the "Steal This Section" at the end of this book.

Form 3.1

**MOVING BEYOND ENROLLMENT
MONTHLY SERVICE INFORMATION**

 Worker Name: Joanne Lee Agency Name: Health, Inc. Month: Feb Year: 200__ Completed: 3/15/00

ID # Household Indiv	MBE Steps	Date	Program Name & Plan	Type of Program or Service	Issues/Barriers/Comments Info worth noting in database	STATUS
C-1234	02 0→8 20→23		*If appropriate*	See *LIST BELOW*	Client Was Completed, Retained, Denied, Terminated, Denied or Not eligible	↓
P-4126	02	0,1	2/3/00	CHIP	HC	has asthma, existing doctor
	03	0,1	"	"	"	
	04	0,1	"	"	"	
P-4330	00	22	2/5/00	medicaid	HC	2 phone calls made
P-2160	01	21	2/7/00	medicaid	HC	assist with redetermination
	02	21	"	"	"	
P-4126	02	2,3	2/27/00	CHIP	HC	able to keep existing doctor
	03	2,3	2/27/00	"	"	
	04	2,3	"	"	"	

Program Types: Health Insurance/Coverage (HC), Medical Services (M), Prescriptions (P), Dental (D), Vision (V), Childcare (C), Transportation (T), Interpreter (I), Other (O)

Status: Completed- no more action necessary (C), Retained or Re-enrolled (RET), Denied for Coverage (D), Terminated (T), Not Eligible for Anything (N)

Page ____

The Monthly Service Information Form allows the program director to track the Moving Beyond Enrollment services provided to each individual. Information for this form is transferred from the Service History forms the outreach workers fill out. This form documents all services provided during the course of one month and serves as the basis for data entry into a program-wide database.

Form 4.0

MOVING BEYOND ENROLLMENT INITIATIVE Monthly Reporting Form

Worker Name: Joanne SmithReport Month: July 2000Completed: 8 / 13 / 00Signature: Joanne Smith**Progress made this month in moving people beyond enrollment to services?**

The front office of our local Community Health Center reports that they saw several first-time patients who said they enrolled in Medicaid through our program, and that they were encouraged by us to come into the Center for preventative care instead of waiting until they were sick.

Difficulties encountered this month preventing people from moving from enrollment to services? Barriers, systematic issues?

We've learned that often billing personnel in providers' offices are confused about how to effectively bill Medicaid; also, when they ask for clarification, they don't have faith in the answers because they have received inconsistent information in the past. Lack of understanding or communication can result in a patient being told they can't receive a service which should be covered.

Next Steps? What are your plans for next month to move people beyond enrollment?

Our next project is to get current and accurate information from our state Medicaid network for our providers. In the longer term, we need to work on ways to improve the communication flow between the state agency and the medical office.

-over-

The Monthly Reporting Form seeks to gather qualitative data on post enrollment issues at the community level. Outreach workers make observations regarding progress, existing barriers and possible next steps. These questions help inform the program director of community issues and prompt the outreach worker to clarify his/her work plan.

**COMMUNITY & PROVIDER ACTIVITIES
-MOVING BEYOND ENROLLMENT-**

Type Activity:	Presentation
Setting:	Large, busy medical office
Target Audience:	Office staff
Description of Activity:	Explained our program and services, how we can help make their work easier and more effective; distributed wallet-sized referral cards.
How effective was it?	Good - received 3 phone calls as a direct result.

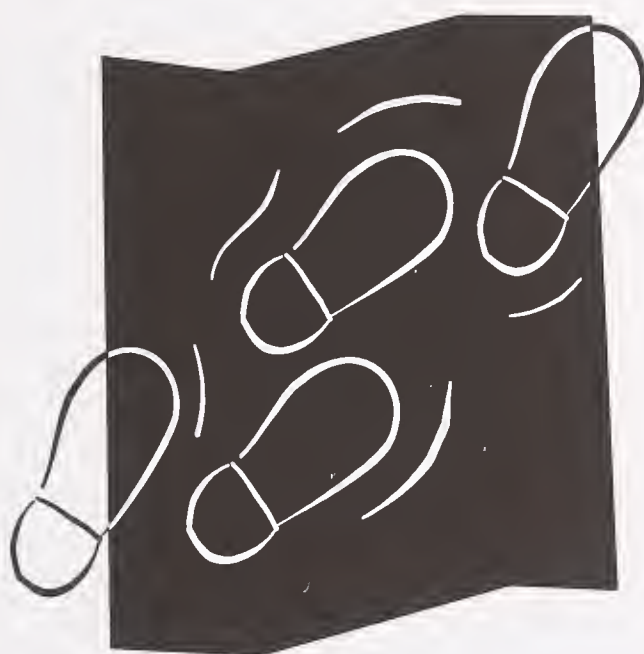
Type Activity:	Marketing / client service
Setting:	Our office
Target Audience:	Our new clients
Description of Activity:	A Welcome kit for new Medicaid enrollees w/ user-friendly information about their primary care provider and managed care plan, names + numbers; also alerts them to the Eligibility Review process + how we can help them maintain their coverage.
How effective was it?	People are happy to get them; time will tell how effective they are!

Type Activity:	
Setting:	
Target Audience:	
Description of Activity:	
How effective was it?	

An ongoing challenge in outreach programs is how to effectively engage the community. The second part of the Monthly Reporting Form requests information about specific activities directed towards community members, health and human service providers, and medical providers. These activities will differ somewhat when promoting post-enrollment support services.

Section V

Resources



CHAPTER 11



Outreach and Health Access Resources

There is a wealth of information and resources available regarding health care access and community-based outreach and initiatives.

This section identifies some of the resources we know best.

This chapter includes:

Materials Developed by
AHEC/Community Partners

Materials Developed by Other
Organizations

National Organizations and
Websites

Health Access Materials

Developed by AHEC/Community Partners

Resources Available on the Web (www.ahecpartners.org/resources/hca)

Health Care Access Tips: Making Outreach Work

More than 30 distinctive outreach strategies gathered primarily from Health Access Networks meetings (*abbreviated version included in Chapter 4*)

Tip Sheets

Who Are the Uninsured, the Underinsured and the Underserved in Rural Massachusetts?

What Are the Barriers to Health Care in Rural Massachusetts?

Considerations for Developing an Outreach Program.

Free Pharmacy Programs: What You Need To Know To Obtain Free Medications

Policy Essays

If We Have the Money, Why Is It So Hard? American Journal of Public Health, September 1998, Tom Wolff, Ph.D. and Michael DeChiara

A Card Is Not Health Care, Michael DeChiara

Truly Reinventing Government, Michael DeChiara

Creating Effective Infra-Structure for Community-based Outreach and Enrollment, Michael DeChiara

Directories Pertinent to Massachusetts Residents

(as available, shipping costs may apply)

Health Access Directory: Statewide and Local Contact Information

A who-to-call resource for doing health care outreach in Massachusetts.

Health Access Networks Participant Directory

An indexed listing of all HAN participants throughout Massachusetts.

Listing of Services Covered at Local Hospitals by the Massachusetts "Free Care Pool"

Information gathered by hospitals and outreach workers from across Massachusetts for the purpose of connecting uninsured or underinsured individuals with health care at local hospitals and health centers.

Health Access Materials

Developed by Other Organizations

Outreach Kit

Center on Budget and Policy Priorities
820 First Street, NE, Suite 510
Washington, DC 20002
202-408-1080
fax: 202-408-1056
www.cbpp.org

A comprehensive guide to creative outreach strategies filled with real-life examples from states and communities where outreach activities are working. Includes fact sheets on Medicaid, welfare program changes, new funds for child health insurance, managed care, and other important information.

Insure Kids Now Kit

Health Resources and Services Administration
U.S. Department of Health and Human Services
1-877-KIDS-NOW (1-877-543-7669)
www.insurekidsnow.gov

The Insure Kids Now kit is intended for use by federal, state and community-based workers to promote outreach and enrollment. Full of generic tools for outreach and marketing including posters, talking points for presentations, overhead transparencies, fact sheets and a CD-ROM with electronic versions of materials.

Information and Support

National Organizations and Websites

AHEC/Community Partners

www.ahecpartners.org
24 South Prospect Street
Amherst, MA 01002
413-253-4283
fax: 413-253-7131

AHEC/Community Partners is committed to developing, promoting, and sustaining community-based efforts across Massachusetts and the nation. The organization's activities seek to increase collaboration within and between communities, build citizen participation, and improve community quality of life. AHEC/Community Partners possesses specific expertise on issues community development, coalition building, and health access, and coordinates the Health Access Networks program highlighted in this book

Center on Budget and Policy Priorities

www.cbpp.org
820 First Street, NE, Suite 510
Washington, DC 20002
202-408-1080
fax: 202-408-1056

The Center on Budget and Policy Priorities is a private, nonprofit research and policy organization that publishes many timely and practical reports on children's health insurance. Their "Start Healthy, Stay Healthy" campaign includes the Outreach Kit (referenced on page 134) as well as posters and flyers in English and Spanish to help spread the word about the availability of free and low-cost health care coverage for children in your community.

Children's Defense Fund

www.childrensdefense.org
25 E Street NW
Washington, DC 20001
202-628-8787

The Children's Defense Fund is a private, nonprofit organization. Their website includes information on signing up children for CHIP (Sign Them Up!), as well as a community CHIP Toolkit, a What's Working series of reports on promising practices,

and a listserv that delivers free information on children's health topics.

Community Catalyst

www.communitycatalyst.org
30 Winter Street
Boston, MA 02108
617-338-6035

The Community Catalyst is a private, non-profit organization. They provide technical assistance to community-based organizations nationwide regarding issues of health access.

Families USA

www.familiesusa.org
Families USA
1334 G St. NW
Washington, DC 20005
202-628-3030 fax: 202 347-2417

Families USA is a national nonprofit, non-partisan organization dedicated to the achievement of high-quality, affordable health and long-term care for all Americans. They provide training and technical assistance to—and work collaboratively with—state- and community-based organizations as they address critical health-care problems in their communities. This website includes lots of useful resources and publications, as well as a sign-up for their listserv, which delivers timely information on health policy issues over email.

HCFA (Health Care Financing Administration)

www.hcfa.gov
7500 Security Boulevard
Baltimore, Maryland 21244
(410) 786-3000

HCFA runs the Medicaid and Medicare programs and jointly runs the Children's Health Insurance Program (CHIP) with HRSA. The agency sets policies and regulates the implementation of these programs. HCFA has established an Outreach Information Clearinghouse <http://www.hcfa.gov/init/outreach/outhome.htm> that offers a range of helpful information to support outreach and enrollment efforts.

HRSA (Health Resources and Services Administration)

www.hrsa.gov

Claude E. Fox, MD, Administrator

Rm 14-05 Parklawn Building

5600 Fishers Lane

Rockville, MD 20857

HRSA directs national health programs as part of the Department of Health and Human Services. HRSA oversees programs focused on improving the nation's health by assuring equitable access to comprehensive, quality health care for all. Notable among HRSA's programs is the 100% Access, 0% Disparities campaign. HRSA and its sister agency, the Health Care Financing Administration (HCFA), work to support outreach and enrollment efforts regarding CHIP and Medicaid. HRSA oversees the Insure Kids Now effort noted earlier.

Kaiser Family Foundation

www.kff.org

2400 Sand Hill Road

Menlo Park, CA 94025

650-854-9400

fax: 650-854-4800

The Henry J. Kaiser Family Foundation is an independent philanthropy focusing on the major health care issues facing the nation. The Foundation is an independent voice and source of facts and analysis for policymakers, the media, the health care community, and the general public. Major health policy initiatives and focus areas include the Kaiser Commission on Medicaid and the Uninsured, the Medicare Policy Project, the Changing Health Care Marketplace Project, minority health, HIV, and women's health policy.

LinkAges Research Group, Inc.

linkages@mediaone.net

P. O. Box 676

Marston Mills, MA 02648

508-420-0963

fax: 508-420-2317

LinkAges Research Group, Inc. provides research and evaluation consulting services to the public and private sectors, with a focus on health care access. This has included design and implementation of evaluations for AHEC/Community Partners' Healthy Connections, Health Access Networks, and Moving Beyond Enrollment programs, as well as consultation to UMass Medical School's MassHealth Access Projects on the evaluation of outreach programs facilitated by this project.

Massachusetts AHEC (Area Health Education Centers) Program

<http://www.umassmed.edu/ocp/programs/ahec.cfm>

Office of Community Programs

University of Massachusetts Medical School

Anderson House 382 Plantation Street

Worcester, MA 01605

508-856-3255 fax: 508-856-6128

The mission of the Massachusetts AHEC Program is to increase access to quality health care through the development of community-academic educational partnerships. AHEC's goal is to improve the supply and distribution of health care professionals with an emphasis on providing primary health care services for the underserved populations. Among Massachusetts AHEC's activities is the nurturing of local coalitions to advocate for appropriate health service delivery systems within their communities, community-based training for medical students and residents, and continuing education opportunities for health care professionals. The Massachusetts AHEC Program staff have been involved in the health access initiatives highlighted in this book.

National AHEC (Area Health Education Centers) Program Office

<http://bhpr.hrsa.gov/dm/ahecmiss.htm>

Division of Medicine

Bureau of Health Professions

HRSA

Parklawn Building, Room 9A-27

5600 Fishers Lane

Rockville, MD 20857

301-443-6950

fax: 301-443-8890

The mission of the Area Health Education Centers (AHEC) Program nationally is to improve the supply and distribution of health care professionals, with an emphasis on primary care, through community/academic educational partnerships, to increase access to quality health care. This mission is accomplished in part by creating systems for learning and networks for information dissemination in support of health care providers in underserved communities, providing technical assistance related to education and training; and contributing to national health policy improving the health care delivery system.

RICHS (Rural Information Center Health Service)

www.nal.usda.gov/ric/richs/

National Agricultural Library, Room 304,

10301 Baltimore Ave.

Beltsville, MD 20705-2351

800-633-7701

ric@nal.usda.gov

RICHES is a national clearinghouse for those seeking information and referral about rural health issues. This resource is available both on-line and via phone and is capable of responding to customized requests. RICHES is operated by a joint effort of the Office of Rural Health Policy and the National Agriculture Library, USDA.

Robert Wood Johnson Foundation/Covering Kids

www.coveringkids.org
c/o Southern Institute on Children and Families
1821 Hampton Street
Columbia, SC 29201
803-779-2607
fax: 803-254-6301
info@coveringkids.org

Covering Kids, a national health access initiative for low-income, uninsured children, is a \$47 million program of the Robert Wood Johnson Foundation to help increase the number of eligible children who benefit from health insurance coverage programs. Three-year grants support 51 statewide and 173 local coalitions in conducting outreach initiatives and working toward enrollment simplification and coordination of health coverage programs for low-income children. Their website includes information about outreach, a newsletter, technical assistance and facts on uninsured kids.

The Urban Institute

www.urban.org
The Urban Institute
2100 M Street, N.W.
Washington, DC 20037
202-833-7200

The Urban Institute is a nonprofit policy research organization. Their website includes reports that use current data to analyze a variety of issues, including enrollment in CHIP, the status of children's health and other related health policy topics. One of their special projects, "Assessing the New Federalism," is a multi-year effort to analyze the devolution of responsibility for social programs from the federal government to the states, focusing primarily on health care, income security, job training, and social services.

CHAPTER 12



Steal This Section

Reinventing the wheel is a waste of time. AHEC/Community Partners is committed to sharing resources whenever possible.

This chapter includes:

Healthy Connections Forms:
Individual/Household Background
Monthly Service Information
Monthly Outreach Summary

Moving Beyond Enrollment
Forms:
Individual/Household Service
History
Monthly Service Information
Monthly Reporting

Health Access Networks Sign-
In Sheet



HEALTHY CONNECTIONS
INDIVIDUAL/HOUSEHOLD BACKGROUND INFORMATION

CONFIDENTIAL

HOUSEHOLD IDENTIFICATION

First Date of Contact with Healthy Connections: ____/____/____
 Address: _____ City: _____ Zip: _____
 Home Ph: (____) _____ - _____ Alt. Ph: (____) _____ - _____

	First Name	Mid.	Last Name	Relationship	Indiv #
Head of Household	_____	____	_____	_____	00
Household member	_____	____	_____	_____	01
Household member	_____	____	_____	_____	02
Household member	_____	____	_____	_____	03
Household member	_____	____	_____	_____	04
Household member	_____	____	_____	_____	05
Household member	_____	____	_____	_____	06
Household member	_____	____	_____	_____	07

Primary Reason for Contacting HC: _____
Referral Source Name: _____ (organization, not person)
Referral Source Type:
☐ Doctor/health care Provider ☐ Hospital ☐ Health Clinic ☐ Religious Org. ☐ Human Service Provider
☐ School/Children's program ☐ Business ☐ Word of Mouth ☐ Libraries ☐ Govt/Public Agencies
☐ Our outreach material ☐ Event ☐ We contacted them ☐ Media ☐ Other ☐ Unknown

ID#: ____ - ____ - ____ - ____	00	01	02	03	04	05	06	07
RACE: Caucasian, African-Am, Asian, Hispanic/Latino, Native Am. Other, unKown (check all that apply)								
GENDER: Male, Female, UnKnown								
AGE or DATE OF BIRTH (month/ year)								
INSURANCE STATUS: Uninsured, Fully Insured, Partially Insured (based on their needs), unKnown								
IF INSURED- TYPE: Indemnity, HMO/PPO, Medicare (MR), Medicaid (MD), CMSP (C), COBRA, COMMonhealth, Unemployment, Community-based (CB), Other, unKnown, N/A								
EMPLOYMENT STATUS: Unemployed, Fulltime, Part-time Seasonal/Temporary, Retired, , unKnown, N/A								
INCOME SOURCE(S): Wages/Earnings, TAFDC, EAEDC, Unemploymt, Soc. Sec (SS) SSI/SSDI (SI), Child Support, Vets Benes, , Pension, Other, unKnown, N/A								
INCOME LEVEL FOR HOUSEHOLD	\$ _____ per/ ____ month ____ year (check one)							
COST OF INSURANCE FOR HOUSEHOLD	\$ _____ per/ ____ month ____ year (check one)							

QUICK INTERACTION- No Detailed Info Possible
 (use this sparingly! all info in Service Grid will be N/A if blank) _____

HEALTHY CONNECTIONS MONTHLY OUTREACH SUMMARY FORM
--

Worker Name: _____

Agency Name: _____

Month: _____ Year: 19____

Date Completed: ____/____/____

NUMBERS SERVED (UNDUPLICATED)

	Households Served	Total People Served	New People Served (first-time contacts)
TOTAL This Month			

TOTAL SERVICES PROVIDED

Add figures from same chart on OW's forms

	Households	Total People	NEW People Served (first contacts)
Referrals Made			
Enrollments Occurred			
Services Received			
Follow-up Contacts Made			
Denials of Referral Occurred			
Assistance Provided (no referrals made)			

Key: Use your Monthly Service Info form to get this information

For Households: If a household has an R,E, etc. it is counted as 1 (ex. Add all households that include an R)

For Total People: Add up the R's, E's, etc. (ex. Add up every R you see to get Referral total)

COMMUNITY CONTACTS MADE BY YOU			
Type of Contact	Name of Group	Type of Group	Who Contacted AND What Purpose

Key: Medical Providers (M), Human Service Providers (H), Schools/Childrens Programs (SC), Religious Orgs (R),
Govt/Public Agencies (G), Business (B) Libraries (L), Events (E), Media (M), Other (O)

WHAT DO YOU SEE THAT WE SHOULD KNOW?

- Community issues regarding gaps or services that should be highlighted
- Examples which capture the service needs of people you've worked with.
- Examples of the positive effects of the program in bringing services to them
- Success stories /Examples of the positive effects of the Program
- Changes in the community (or our program) in policies, practices or programs

Outreach worker Signature

Date Completed

CONFIDENTIAL

Form 2.1

MOVING BEYOND ENROLLMENT
INDIVIDUAL/ HOUSEHOLD SERVICE HISTORY (office use)

Household ID# ____ - ____ Individual ID# ____ Name: _____
 Address: _____ Town: _____ Zip: _____
 Phone: _____ Alt. Phone: _____
 Has existing relationship with a provider: Yes__ No__ If yes, name: _____
 Existing Health Coverage Programs: _____ Plan: _____

Health/Medical Continuum

MBE Step	Description	Date	Done	Comments
0	Referral Made			
1	Eligibility Confirmed			
2	Provider & Plan Selected			
3	Describe Program; How to Use System; Why Prevention is Good			
4	Confirmation- Everything in Order			
5	Successfully Enrolled!			
6	Initial Appt Made OR Confirm Existing Provider Relationship			
7	Initial Visit Completed OR Appropriate Services Received			
8	Post-Service Assessment Done			

RELATED MBE ACTIVITIES

Code	Date	Comments	Code	Date	Comments

20- Arrangements for Addt'l Medical/Related Services
 22- Follow-up Activity

21- Retention/Re-enrollment Activity
 23- Misc. Assistance/Activity

Client Related Information:

Provider Name: _____ Health Plan: _____
 Other: _____
 Initial Appt Date: _____ Time: _____
 Medical Needs: _____

Status: (record on monthly service form)

Completed/No More Action Necessary (c) ____ Retained/Re-enrolled (RT): ____
 Denied for Coverage (d): Date: ____ Not Eligible for Anything (n): ____
 Terminated (t): Date: ____

Form 4.0

MOVING BEYOND ENROLLMENT INITIATIVE
Monthly Reporting Form

Worker Name: _____

Report Month: _____ 2000

Completed: ____/____/____

Signature: _____

Progress made this month in moving people beyond enrollment to services?

Difficulties encountered this month preventing people from moving from enrollment to services? Barriers, systematic issues?

Next Steps? What are your plans for next month to move people beyond enrollment?

-over-

**COMMUNITY & PROVIDER ACTIVITIES
-MOVING BEYOND ENROLLMENT-**

Type Activity:	
Setting:	
Target Audience:	
Description of Activity:	
How effective was it?	

Type Activity:	
Setting:	
Target Audience:	
Description of Activity:	
How effective was it?	

Type Activity:	
Setting:	
Target Audience:	
Description of Activity:	
How effective was it?	

Health Access Network Meeting Sign In Sheet _____ HAN Region _____ Meeting Date: _____ / _____ / _____ Convener: _____

If you have signed in before – Please include only your name and organization unless your information has changed, e.g. you've moved office or if you now have e-mail

1

NAME	PHONE W/ AREA CODE ()	YOUR POSITION
ORGANIZATION	FAX W/ AREA CODE ()	
ADDRESS	ZIP CODE	EMAIL

2

NAME	PHONE W/ AREA CODE ()	YOUR POSITION
ORGANIZATION	FAX W/ AREA CODE ()	
ADDRESS	ZIP CODE	EMAIL

3

NAME	PHONE W/ AREA CODE ()	YOUR POSITION
ORGANIZATION	FAX W/ AREA CODE ()	
ADDRESS	ZIP CODE	EMAIL

4

NAME	PHONE W/ AREA CODE ()	YOUR POSITION
ORGANIZATION	FAX W/ AREA CODE ()	
ADDRESS	ZIP CODE	EMAIL

5

NAME	PHONE W/ AREA CODE ()	YOUR POSITION
ORGANIZATION	FAX W/ AREA CODE ()	
ADDRESS	ZIP CODE	EMAIL

Afterword

We wrote this book because of our firm belief that community-based outreach makes a difference in expanding health coverage. We have learned in Massachusetts that any successful attempt to engage people around health access programs must include communities. We have also learned that outreach efforts need to be supported through programs which promote networking and information exchange. Both functions must be in place for initiatives to thrive.

The material in this book seeks to provide “on the ground” lessons and practical information. We encourage you to take what you can and apply it to your own situations. In turn, we ask that as you explore, develop tools and learn lessons, you share them generously with others. There’s no time to reinvent the wheel.

In closing, we wish to share two underlying convictions. First, health care is a right of all people. Second, the United States must ultimately embrace a fair system in which all its residents have affordable access to quality health care.

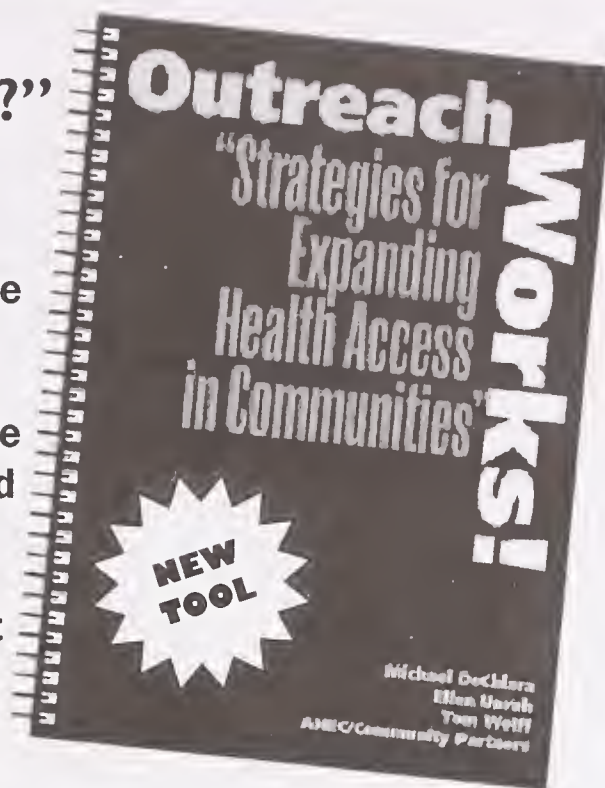
Thank you for your interest in making health access a reality for the millions who still need it.

Working on health care access but still puzzling over the question ...

**“IF COVERAGE IS AVAILABLE,
WHY IS ENROLLMENT SO DIFFICULT?”**

OUTREACH WORKS INCLUDES:

- o Over 140 pages of field-tested, jargon-free information
- o Nuts-and-bolts information needed to create and support effective community-based outreach efforts
- o Examples of successful models and best practices regarding outreach and enrollment



“This useful book provides proven models and helpful how-to information for making outreach work” - Ron Pollack, Executive Director Families USA

SPECIAL OFFER!

Bolster your knowledge of working with communities by adding the authoritative resource on community building, **From the Ground Up!** and **Outreach Works** to your library and **SAVE \$10.**

Outreach Works & From the Ground Up! at a special **\$45** rate

To order additional copies of **Outreach Works** and receive a catalog featuring the full line of

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COMMUNITY-BASED OUTREACH and
HEALTHY COMMUNITIES**
resources available from AHEC/Community Partners

complete the order form below
or find us on the web at

WWW.AHECPARTNERS.ORG

Order **Outreach Works** via our website, fax or mail. **VISIT WWW.AHECPARTNERS.ORG** or **FAX 413-253-7131** or **MAIL** to: AHEC/Community Partners, 24 South Prospect Street, Amherst, MA 01002, Attn. Outreach Works

Name _____

Shipping Address _____

Organization _____

Telephone _____

Billing Address _____

Email _____

_____ **Outreach Works @ \$25** _____ **Special Offer! @ \$45** **Total Due \$** _____ (include 10% Shipping)

Method of Payment: ☐ Bill me ☐ Check/Money Order Enclosed (U.S. \$ only) Materials shipped at book rate

Questions? Call us at 413-253-4283 or Email us at info@ahecpartners.org

"This is a must read for people doing or designing health access outreach initiatives!"

— Catherine Dunham, Executive Director,
The Access Project

"This useful book provides proven models and helpful how-to information for making outreach work."

— Ron Pollack, Executive Director,
Families USA

"*Outreach Works* is essentially the tale of two strategies. When married together these two strategies strike a proven formula for helping uninsured individuals get the health coverage for which they are eligible and access to the care they need... This dual approach has helped to make Massachusetts one of the states that has made significant strides in reducing the number of uninsured residents."

— Donna Cohen Ross, Director of Outreach,
Center on Budget and Policy Priorities

"Progress would not have been possible if community organizations did not organize to reach out to their communities. This book provides important information on how Massachusetts was able to expand enrollment in communities and develop effective partnerships."

— Mark Reynolds, TennCare Director,
Tennessee Medicaid Program

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fax: 413.253.7131

